ISER
Facilitating Social Justice
INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS

THE HUMAN RIGHTS IMPACT OF COMMERCIALISATION OF PUBLIC SERVICES IN EAST AFRICA

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Introduction

1. Introduction

African countries are parties to numerous international and regional human rights instruments which oblige their governments to take a central role in providing and financing public services. Over the past three decades, the private sector has become a major actor as a provider and financier of public services in Africa. This study investigated how the involvement of private actors in the service delivery and financing of social sectors over the past three decades has impacted the role of States in meeting their human rights obligations. It focuses on health and education service delivery and financing in the East African region, particularly, Uganda, Kenya, Tanzania and Rwanda.

Private sector participation in the education and health service delivery is not a new phenomenon. Prior to the 1980's, some African countries permitted private institutions to provide services although the government played a dominant role in the provision and regulation of these services. The increasing involvement of the private sector in the health and education sectors can be traced back to the economic reforms adopted during the Washington Consensus. Numerous studies have demonstrated that the market oriented reforms adopted in that era laid the ground for commercialization of public services. From a human rights perspective, the profit driven motive behind private provision of public services is a key concern especially with respect to availability and access to quality services for low income households and vulnerable groups.

This study aims to analyse how commercialization of public services, specifically in the health and education sectors, has unfolded in the East African region. It discusses the historical background and current context of commercialization in the selected study countries (Section 2). It examines the relevant legal and policy framework governing provision of health and education services in the region and how it pertains to commercialisation (Section 4). The study presents findings on the impact of the ongoing commercialization of health and education services under a human rights lens and makes recommendations.

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1 See Section 2 of this report below.

2 United Nations General Assembly, 'Report of the Special Rapporteur on extreme poverty, Philip Alston' A/73/396 at para 7.
See also, Kate Bayliss and Tim Kessler, "Can Privatization and commercialisation of public services help achieve the MDGs? An Assessment" (2006) International Poverty Centre, United Nations Development Programme (UNDP) Working paper No. 22.

3 Ibid.

4 United Nations General Assembly, Ibid at para 3.

2

Historical background and current context of commercialization of social services in East Africa

2. Historical background and current context of commercialization of social services in East Africa

This section briefly looks at the historical background of the ongoing commercialization of health and education services in Uganda, Kenya, Rwanda and Tanzania. It also discusses the current context on health and education service delivery under which commercialization is rapidly growing in the region. Specifically, it highlights the stance of the various governments on their provision of these crucial social services alongside private actors.

Box 1

Key features on the historical background and current

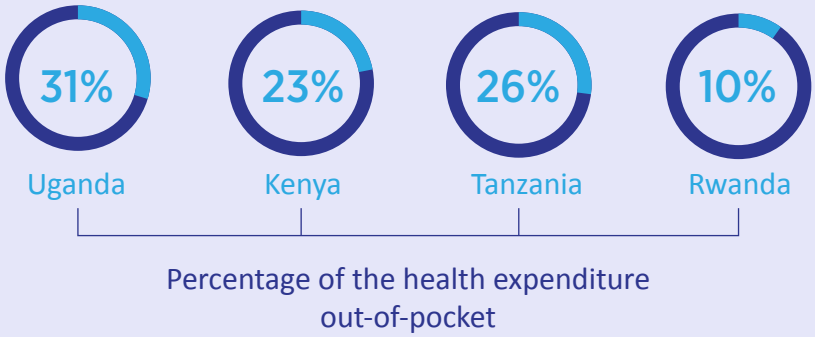
1. All the study countries adopted economic and fiscal reforms under the International Monetary Fund and the World Bank Structural Adjustment Programs (SAPs) such as liberalization, privatization and deregulation in exchange for aid and loans in the 1980's and 1990's.

2. Resultantly, the low public investment and weak regulation of the private involvement in social service delivery has bred commercialization of public services. Private actors are increasingly encouraged to provide health and education services alongside the government albeit with varying degrees of regulation. Public schools and health facilities are also charging for services and these costs remain largely unregulated in the region.

3. Tanzania specifically had a strong regulatory hold over service delivery by private actors in the 1960s and 1970s but these were relaxed during the 1980's SAPs era. For instance, the country previously banned private provision of health services but later lifted the ban in the 1990's.

4. All the study countries provide free basic education at primary and secondary level in public schools. However, only Rwanda and Kenya have capped the tuition costs at public and subsidized schools. None of the countries have a harmonized school fees structure in place for private schools.

5 On the health front, according World Health Organization (WHO) data (2021), populations of all the study countries still pay a high percentage of the health expenditure out-of-pocket – Uganda (31%), Kenya (23%), Tanzania (26%) and Rwanda (10%).[5]



6 Tanzania's National Health Insurance Fund (NHIF) attempted to set a structure for charges by hospitals, however, it has been halted due to pressure from private health service providers.

Uganda

Historically, formal education and modern health services were introduced in Uganda by the Christian missionaries who had established their foothold before the eventual colonization by the British in the late 19th Century.[6] It is this historical position that explains the special position and role that the non-state actors especially the religious institutions, like the church continue to play in the delivery of the social services. Upon attaining independence in 1962, the post-colonial governments undertook to expand access to education and health services. This was mainly done either directly - constructing several primary and secondary schools and health facilities[7] - and partnering with religious-founded schools and health facilities through grant–aiding.

[5] World Health Organisation (WHO), Global Health Observatory data repository available at https://apps.who.int/gho/data/view.main.GHEDOOPSCHESHA2011v (accessed on March 1, 2024).
[6] Ministry of Education and Sports (MoES), "National Education Accounts Report" (2016) at p. 1.
[7] Ibid.

From 1960 – 1971, Uganda's health system was ranked the best in Sub–Saharan Africa with well-equipped and staffed hospitals and a set of connected health units.[8] By independence, the country boasted of 27 hospitals and more than 22 rural hospitals were built shortly after independence.[9] Public hospitals provided free health services while faith–based health facilities offered low-cost services.[10] However, the delivery of free and affordable health services was short-lived. Political crises in the country from the mid-1960s and eventually the 1971 coup that forced several medical professionals to flee the country coupled with the economic meltdown that incapacitated the State's provision of health services. During this period of instability, non–state actors such as non-governmental organisations, faith-based institutions and the private sector both formal and informal gradually increased their participation in health care delivery with hardly any statutory oversight over their operations.[11] The public health service system was gradually weakening and facilities begun charging informal costs.[12]

On the education front, parents and guardians paid school fees for their children at primary and secondary level however, the government regulated the sums charged in all government and grant-aided primary and secondary schools.[13] In 1970, the government enacted the Education Act that explicitly provided for private provision of education. It set the requirements for establishing a private school including permission to operate a new school through the issuance of a license, registration of private schools and a Private Schools' Register.[14] The Act also made provision for the regulation of school fees in all schools.[15] Consequently, the Education (Primary School Fees) Regulations **SI 127—5** and the Education (Post-primary Institutions School Fees) Regulations, **SI 127—6** were issued to

[8] Norman Mukasa, "Uganda Healthcare system profile: Background, Organization, Polices and Challenges," (2012) Journal of Regional Sustainable Health System, Issue. 1, Vol. 1, 2012 at p. 2.
[9] African Centre for Global Health and Social Transformation (ACHEST), "A Study of Health Reforms in Uganda: Lessons for the Health Sector Strategic and Investment Plan, 2010/15, 2011," at p. 3.
[10] Ibid, at p.3
[11] Ibid.
[12] Ministry of Health, "National Policy on Public Private Partnerships in the Health Sector," at p. 10.
[13] See for instance, the Education (Primary School Fees) Regulations, SI 127—5; The Education (Post Primary Institutions School Fees) Regulations, SI 127—6. The School Fees Regulations that were issued and provided for allowable school charges in government and grant–aided schools for rural and urban; day and boarding
[14] Government of Uganda, The Education Act Cap 127, Sections 23 – 27.
[15] Ibid, Section 43 (g).

regulate the school fees charged in public day and boarding schools in both rural and urban areas.[16]

The political turmoil and instability from 1966 to 1986 impacted the country's economic development, resultantly reducing its resources – both human and financial capacity - to meet its education and health services demands and obligations.[17] In the late 1980s, like most least – developed countries, Uganda undertook SAPs in its economic and governance structures, including the social service sector as pre – condition to access financing from the Bretton Woods Institutions for its fiscal deficits. It introduced market-driven principles of liberalization, deregulation, cost – sharing among others into the economy generally, and in the social service sector in particular.[18]

In the health sector, liberalization was informed by the need to expand access to healthcare services and cost–sharing, through user fees, was introduced to increase revenue for the struggling public health facilities.[19] However, the reforms did not achieve the objectives for which they were introduced. For instance, the user fees raised minimal revenues and were a significant barrier to access for services for poor and vulnerable people.[20] This triggered another set of reforms in the late 1990s. The key features included the abolition of user fees, with effect from 2001, in all public health facilities except in private wings and formalizing of public-private partnerships, especially with respect to the private not-for-profit health facilities.[21]

With respect to education, the 1992 Government White Paper on Education, prepared in response to the SAPs, recommended the liberalization of education. This was eventually actualized in 1993 with the rationale of allowing the private

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[16] These Regulations were not revoked by the Education Act of 2008. However, taking into consideration the raise in inflationary rates over the years, in their current form, they are of no consequence.

[17] Yates, et al, "The Ugandan health systems reforms: miracle or mirage?" in Christine Kirunga Tashobya, Freddie Ssengooba and Valeria Oliveira Cruz (eds), "Health Systems Reforms in Uganda: processes and outputs" Health Systems Development Programme, London School of Hygiene & Tropical Medicine, UK at p.16.

[18] Ibid at p. 17.

[19] Kirunga et al, supra at p.46.

[20] Yates, et al, supra, p.16.

[21] Ibid, p. 17.

sector to supplement the efforts of the state in the provision of education.[22] In 2008, the Education Act was enacted to give effect to this policy position. One of the objectives the Act is to promote partnership with the various stakeholders in providing education services.[23] The Act also recognizes school fees as one of the major sources of financing education and provides for processes and procedures for establishing private schools.[24]

Liberalization of the education sector was not backed by a strong legal and policy framework to effectively regulate the operations of private actors.[25] There has been an exponential growth in the numbers of private schools especially at the secondary level. In 2007, when the government commenced the implementation of the Universal Secondary Education (USE) program, it engaged the private schools in the first formal public, private partnership (PPP) arrangement.[26]

571 under PPP

916 under Govrnment aid

Of the 1,487 USE schools, 571 were under the PPP arrangement and 916 under the government-aided arrangement.[27] However, in 2014, the President directed the phasing out of the PPP scheme in USE such that the funds can be utilized to construct government secondary schools in sub-counties out public secondary schools.[28] In 2018, the Ministry of Education and Sports commenced the phasing out of the PPP scheme in USE.[29]

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[22] Initiative for Social and Economic Rights (ISER), 'Threat of Opportunity: Public Private Partnership in Education in Uganda,' (2016) at p. 3.

[23] Government of Uganda, The Education (Pre – Primary, Primary and Post – Primary) Act, 2008, Section 1 (e).

[24] Ibid, Section 4(3).

[25] Prisca Wanyenya, Parliament Issues 6months Ultimatum on Private Schools Policy, Parliament Watch, November 7, 2023 at https://parliamentwatch.ug/news-amp-updates/parliament-issues-6-months-ultimatum-on-private-schools-policy/ (accessed on December 15, 2023).
ISER, supra.

[26] Ministry of Education and Sports, Education Statistical Abstract, 2017.

[27] O'Donoghue et al, "A review of Uganda's Universal Secondary Education Public Private

[28] Partnership programme," Education Partnerships Group, 2018, P.7 at https://epg.org.uk/wp-content/uploads/2019/05/Uganda-PPP-Review_2018_Final.pdf (accessed on December 14, 2023).
Ahimbisibwe P, "Govt to stop funding to 800 private USE schools, Daily Monitor," Wednesday,

[29] January 17, 2018 — updated on January 13, 2021 at https://www.monitor .co.ug/uganda/news/national/govt-to-stop-funding-to-800-private-use-schools-1736078 (accessed on December 14, 2023).

Table 1: Ownership of health facilities and secondary schools in Uganda

Ownership of secondary schools in Uganda					
	Religious institutions (Anglicans - COU, Catholics, Islam, SDA)	Entrepreneurs	Community	Others	Government
Number of schools	1,199	895	452	260	189

Source: Ministry of Education and sports, Education Statistical Abstract, 2017

Ownership of health facilities in Uganda			
Ownership	Government	Private for Profit	Private not-for- Profit
Number of health facilities	3,133	2,976	1,008
Percentage (%)	45.16	40.31	14.53

Source: National Health Facility Master List, 2018

In comparison with the post-independence period, Table 1 shows that the quantity of private for-profit health facilities and schools has risen significantly. This trend coincided with stagnated or even reduced public spending for health and education under the national budget. A case in point is the public financing of the Universal Primary Education (UPE) program. The National Planning Authority (NPA) has indicated that the operational funds (capitation grants) of UGX 20,000/= (approx. $5) allocated to primary schools for each learner are grossly inadequate.[30] It concluded that UPE was

[30] Nafula Jane, "Increase capitation grant, NPA tells government" September 15, 2023, Daily Monitor available at https://www.monitor.co.ug/uganda/news/national/increase-capitation-grant-npa-tells-govt-4369848 (accessed on March 31, 2024).
See also, National Planning Authority (NPA), "Comprehensive Evaluation of the Universal Primary Education (UPE) Policy, Thematic Report 5: Financing and Costing of UPE," 2018, p. xiii.

therefore not free but subsidized primary education and parents and guardians had to shoulder additional financial obligations for their children's education.[31] The Ugandan cabinet recently issued a directive restricting all schools from charging certain charges as part of their school fees structure including infrastructure development, purchase of property, salaries of employees, legal fees, loans and charges to facilitate the various governing bodies.[32]

Kenya

At independence in 1963, the government supported and encouraged various stakeholders to participate in social service delivery with the major goal of responding to the challenge of poverty which was hindering the country's socioeconomic progress.[33] In 1960s and 1970s, the independent government abolished fees in schools which resulted in an increase in school enrollment.[34] Free education was introduced between 1974 – 1978 which increased enrolment in schools.[35] However, in the 1980s, Kenya adopted SAPs with a major feature of reduction in public expenditure and encouragement of cost sharing in the education sector.[36] As a result of the prohibitive school fees, many disadvantaged children, especially girls, from rural communities, the urban poor and children

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[31] NPA, ibid. NPA further recommended that to eliminate non–tuition fees in schools implementing UPE, the government allocates capitation grant allocation of UGX 59,503 and UGX 63,546 per pupil per year in rural and urban schools respectively to enable schools to meet the operational costs. The allocation has since been slightly enhanced to UGX 20,000 despite the increase in inflation over the years.

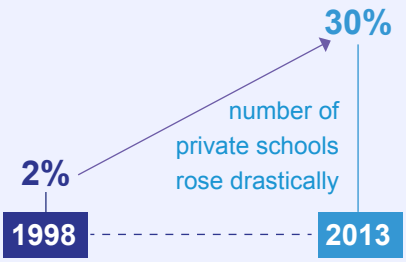
[32] Daily Monitor, "Government to close schools over high fees' (2024) available at https://www.monitor.co.ug/uganda/news/national/govt-to-close-schools-over-high-fees--4538742 (accessed on February 29, 2024).

[33] Linda Oduor-Noah, "The Growth of Private Actors in Education in East Africa, in Adamson et al (eds), "Realizing the Abidjan Principles on the Right to Education," (2021) Edward Elgar Publishing Limited, Cheltenham at p.190.
See also, the Global Initiative for Economic, Social and Cultural Rights (GIESCR) et al, "Kenya's support to privatization in education: the choice for segregation? Preliminary parallel Report submitted on the occasion of the examination of the report of Kenya during the 56th session of the UN Committee on Economic, Social and Cultural Rights," (2015), P.5 at https://www.ecoi. net/en/file/local/1323046/1930_1461153384_int-cescr-ngo-ken-22040-e.pdf accessed November 19, 2023.

[34] Ibid.

[35] Action Aid, "Multi-country research on private education in compliance with the right to education: A study of Ghana, Kenya and Uganda," (2019) at p.33.

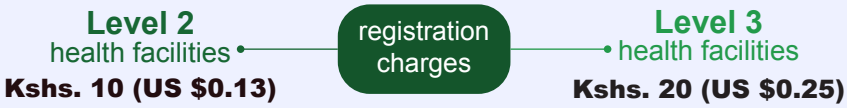
[36] GIESCR, 2015, supra, p.5.



with disabilities dropped out of formal education.[37] The other outcome of SAPs was the exponential promotion of the private sector involvement in education. The number of private schools rose drastically from 2% of all primary schools in 1998 to 30% by 2013.[38]

Interestingly, the growth of the private sector in education has continued to rise despite the introduction of the Free Primary Education program in 2003 and the Free Secondary Education program in 2008. This has been largely attributed to the massive influx of students into public schools and the resultant deterioration in quality due to overstretched facilities as well as a limited number of public schools, especially in urban informal settlements.[39] This contributed to the rise of low-fee private schools in these areas which reportedly operate with low numbers of qualified teachers, therefore providing education whose quality has been questioned.[40]

With respect to the health sector, for a long time, paying charges to access health services has been the norm in Kenya. In 2004, the government abolished user fees in public dispensaries and health centres (level 2 and 3 health facilities) and replaced them with registration charges of Kshs. 10 and 20 (equivalent of US $0.13 and $0.25) for the respective facilities.[41]

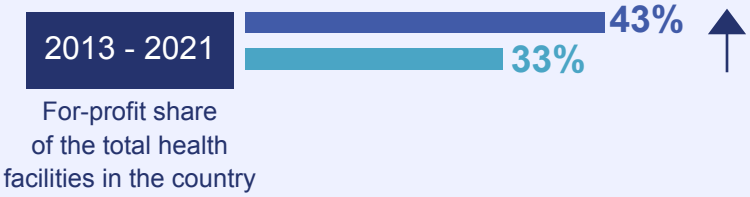


However, there were exemptions for certain services such as treatment for malaria, tuberculosis (TB) and sexually transmitted diseases, all care for under

[37] Ibid.
[38] Kenya economic surveys, 2002-2014 cited in Action Aid, 2019, supra, p. 36.
[39] James Tooley et al, "Impact of free primary education in Kenya: a case study of private schools in Kibera," (2008).
[40] Moses Ngware et al, "Quality and Access to Education in urban informal Settlements in Kenya," (2013) African Population and Health Research Center at p.58-59.
[41] Dennis, M.L., Benova, L., Goodman, C. et al. "Examining user fee reductions in public primary healthcare facilities in Kenya, 1997–2012: effects on the use and content of antenatal care" Int. J Equity Health 19, 35 (2020).

5-year-olds, deliveries, and antenatal care (ANC) and patients from poor households.[42] In 2013, Kenya adopted a devolved system of government under which County Governments are responsible for mobilizing the majority of funding for primary and secondary health service delivery while the national government provides some commodities and drugs to primary care facilities.[43]

Since independence, private health providers, especially the not-for-profit actors, have been part of the country's health system. However, over the years, for-profit health providers have considerably increased their coverage in the country. It is estimated that between 2013-2021, the percentage of for-profit share of the total health facilities in the country increased from 33% to 43% in less than 10 years.[44] This can largely be attributed to the favorable policy environment from the 1980s and 1990s characterized by lessened licensing and regulation of private healthcare providers.[45] The reduction in public health expenditure and the charging of user fees in public health facilities also played a part. The Kenya Health Policy 2014-2030 cemented the government's stance. Its key objective is to strengthen the private sector as both a financier and a provider, including through financial incentives such as tax exemptions and private-public partnerships.[46]



[42] Antony Opwora et al, "Implementation of patient charges at primary care facilities in Kenya: implications of low adherence to user fee policy for users and facility revenue" (2015) Health Policy and Planning, Volume 30, Issue 4.

[43] Kenya Ministry of Health, "Kenya Health Financing Strategy (2020-2030).

[44] Ministry of Health, "Kenya Service Availability Readiness Assessment Mapping (SARAM) Report" at p. 12. Nevertheless, the number of private actors in the health sector has remained below the number of public health facilities. The 2015 Ministry of Health Master Facility List, indicated that out of the 9,362 health facilities, 46% are public while faith-based organizations and private for–profit constituted 54% (5,083 facilities) of the total health facilities. The 2020 Health Master Facility List indicates that 37.8% (5,080 facilities) of the health facilities are under the ownership of the private sector (faith-based and for–profit), representing a 16.2% decline. See Ministry of Health, "Kenya National Health Accounts 2015/2016" (2019) at p. 4. See also, Ministry of Health, "Kenya Master Health Facility List" (2020).

[45] Muthaka et al, "A Review of the Regulatory Framework for Private Healthcare Services in Kenya" (2004) Kenya Institute for Public Policy Research and Analysis (KIPPRA) Discussion Paper No. 35.

[46] Ministry of Health, 'Kenya Health Policy 2014-2030', 2014

Notably, Kenya runs the oldest government health insurance scheme in Africa established in 1966. Cognizant of the changing needs of the population, reforms in employment and the restructuring of the health sector, for instance, the growth of the private sector, legal reforms were undertaken in 1998. NHIF membership was compulsory for all salaried employees and voluntary for self-employed.[47] There is also voluntary private health insurance offered by general insurance firms as one of their products but it is mainly driven by profit.[48] There are also community-based health insurance schemes which have grown relatively slowly.[49] Despite the compulsory coverage (especially for formal workers), it is not uncommon for some individuals and households to also have private health insurance packages due to the challenges associated with government insurance.[50] For instance, the Kenya Medical Association has pointed out that low funding, low capacity, and inadequate supplies affect the performance of public health facilities.[51]

The most recent major development in the health sector is the passing of the Social Health Insurance Act which abolished the NHIF in 2023 and replaced it with Social Health Insurance Fund. Under the new law, Kenyan households and persons who ordinarily reside in the country are required to contribute to the Social Health Insurance Fund.[52] The State intends to pay the contribution on behalf of households which cannot afford.[53] The Act permits Social Health Authority to contract any healthcare service providers, public or privately owned, to provide health insurance.[54]

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47 National Hospital Insurance Fund Act Cap 255, Section 15 and 20.

48 Mugo, M.G, "The impact of health insurance enrollment on health outcomes in Kenya," (2023) Health Econ Rev 13, 42. See also, Kimani DNet al, "Catastrophic health expenditures and impoverishment in Kenya" Eur Sci J. (2016).

49 Kimani JK. et al, "Determinants for participation in a public health insurance program among residents of urban slums in Nairobi, Kenya: results from a cross-sectional survey" BMC Health Serv Res. (2012).

50 Mugo, M.G, (2023) supra.

51 Wairimu Mwaniki and Leon Ogoti, "Challenges facing the attainment of Universal Health Coverage in Kenya" Kenya Medical Association available at https://kma.co.ke/component/content/article/79-blog/125-challenges-facing-the-attainment-of-universal-health-coverage-in-kenya?Itemid=437#:~:text=These%20key%20gaps%20in%20resource,Universal%20Health%20Coverage%20in%20Kenya (accessed on February 6, 2024).

52 The Social Health Insurance Act, Sections 26 and 27 and the Social Health Insurance (General) Regulations, 2023, Regulations 16 (1) and 17 (1).

53 The Social Health Insurance Act, Sections 27 (2).

54 The Social Health Insurance Act, Section 31 and Section 2 of the Health Act, No. 21 of 2017.

Rwanda

At independence, the management and provision of education and health services in the country were largely under the control of the State. Even with the global economic meltdown of the 1980s that forced many countries to adopt neoliberal policies which impacted their social sectors, the government of Rwanda was initially hesitant to adopt the structural adjustment programs.[55] While the government eventually gave in during the 1990s due to rising economic pressures, the implementation of the policies was derailed first by the outbreak of civil war and later on, the 1994 Rwanda genocide.[56] At the end of the genocide, as part of the recovery of social sectors, the government re-embarked on the plan to introduce market-oriented principles in social service delivery including the involvement of private actors.

Just like in Uganda, formal education in Rwanda was started by the Christian missionaries and they continued to participate in the provision of education in the post-independence era.[57] The State would appropriate funds to finance the operation of the church-founded schools.[58] In 1965, the Catholic Church and the government agreed to nationalize several church schools, resulting in the classification of schools into three: public, private, or assisted.[59] By 1993, parents' associations, youth movements, charity groups or religious institutions such as the National Secretariat for Catholic Education (SNEC), the National Bureau for Protestant Education (BNEP), and the Association of Muslims (BNAM) had built more schools that were grouped under the Rwandese Federation for Private Education (FREP).[60] Following the introduction of free basic education in 2003, the country has continued a hybrid system of education consisting public, government subsidized and private schools.[61] Among the private and government

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55 Dan Imaniriho, "Local Ownership of Education Policies at the Crossroads between the Active Participation and the Passive Compliance to International Goals," (2015) Journal of Education and Practice, Vol.6, No.2 at p.48.

56 Ibid.

57 Bridgeland et al, "Rebuilding Rwanda: From Genocide to Prosperity Through Education," (2009) Civic Enterprises, LLC & Hudson Institute at p. 5.

58 Ibid.

59 Ibid.

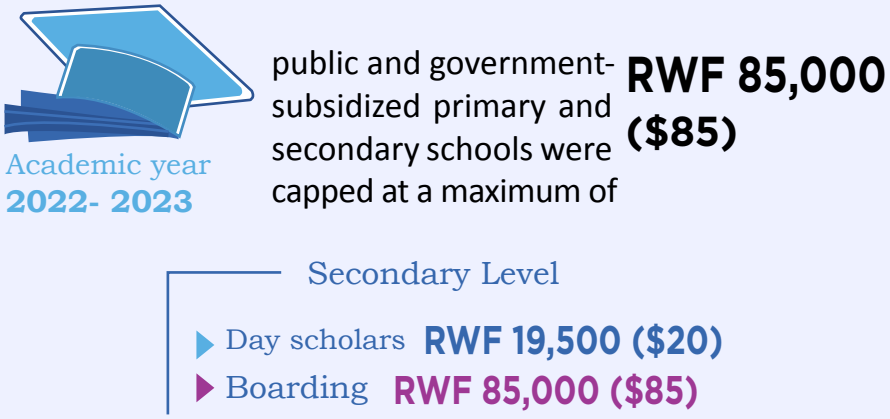
60 Ministry of Education, Study of Education Sector in Rwanda, Kigali, Revised edition 1998, p. 37-38).

61 Ministry of Education, Education Sector Strategic Plan 2018/19 to 2023/24, Republic of Rwanda at p. 7.

subsidized schools include schools owned by religious institutions and communities, individuals or associations, NGOs.[62]

The introduction of free basic education in public schools was intended to enable children from poor backgrounds to access education, however, parents are required to make contributions, often beyond their means.[63] This prompted the Minister for Education to regulate the school fees charged in public and government subsidized schools where 90% of the slightly over 4 million learners in Rwanda are enrolled.[64]

Thus, in the academic year 2022-2023, the school fees charged in public and government-subsidized primary and secondary schools were capped at a maximum of RWF 85,000 ($85).[65] At secondary level, fees were capped at RWF 19,500 ($20) for day scholars and RWF 85,000 ($85) for boarding.[66]



[62] UNESCO, "Rwanda: Non – state actors in Education" at https://education-profiles.org/sub-saharan-africa/rwanda/~non-state-actors-in-education accessed on December 4, 2023.

[63] The East African "Rwandan parents seek govt's help to stop further increase in fees," September 30 2016 at https://www.theeastafrican.co.ke/tea/rwanda-today/news/rwandan-parents-seek-govt-s-help-to-stop-further-increase-in-fees--1356020 (accessed on December 4, 2023).

[64] United Nations Children Fund (UNICEF), "Education Budget Brief, Investing in Child Education in Rwanda FY 2022/23," (2022) at p. 4.

[65] Lliza Ange "Public School Fees capped at $85 to meet 'Education for All' national goal" Rwanda Today, September 21, 2022 at https://rwandatoday.africa/rwanda/news/public-school-fees-capped-at-85-to-meet-education-for-all-national-goal-3956612 (accessed on February 01, 2024).

[66] Ibid.

The government is also currently implementing a school feeding policy that is a shared obligation between the government and parents. With the average cost of a meal at RWF 150 ($0.15) per student, the government contributes RWF 56 per student per meal while the parents meet the rest of the cost.[67]

RWF 150 ($0.15) is the average cost of a meal per student

the government contributes RWF 56 per student per meal

On the health front, the country runs on a hybrid system of health service delivery composed of public, commercial and nonprofit health facilities.[68] Private sector involvement in health service delivery gained momentum in the 1990's and has been growing since although the number of public health facilities outnumber the private ones. Currently, out of a total of 2,067 health facilities, 86% (1,788) are publically operated.[69]

Out of **2,067 Health facilities**
86% (1,788) are publically operated

Similar to Kenya, Rwanda runs a public health insurance scheme, the Rwanda Health Insurance Scheme (La Rwandaise d'assurance maladie - RAMA) established in 2001.

Formal sector employees contribute an equivalent **15%** of their salaries

7.5% by the employee

7.5% by the employer

[67] Republic of Rwanda, Ministry of Education, Rwanda School Feeding Operational Guidelines Summary at p. 6.

[68] Overview of the Health System in Rwanda at https://dhsprogram.com/pubs/pdf/spa3/02chapter2.pdf (accessed on December 5, 2023).

[69] Ministry of Health, Annual Health Sector Performance Report FY 2021/ 2022, Government of Rwanda, p.16 and 78.

Formal sector employees contribute an equivalent of 15% of their salaries – 7.5% by the employee and 7.5% by the employer.[70] In 2005, the Military Medical Insurance (MMI) scheme was launched for the members of military service and their immediate family members.[71] The country also relies on the Community Based Health Insurance (CBHI) to cover its population working in the informal sector.[72] The contributors and beneficiaries receive medical services in public as well as private facilities and pharmacies that are contracted to offer health insurance services.

However, this notwithstanding, the beneficiaries of the various health insurance packages, often times, still pay up to **10%** of their healthcare cost out of pocket.[73]

Tanzania

In the immediate aftermath of independence, Tanzania's social sector policies were shaped by political ideologies. The 1967 Arusha Declaration of Socialism and Self Reliance (Ujamaa) is the benchmark for the education and health service delivery reforms. Its objective is to make services accessible to all persons, especially the vulnerable and marginalized groups.[74] Private schools (run by missionaries) were nationalized by the government and transformed into public schools in the 1960s and 1970s under the slogan of 'free and universal public education'.[75] Education law and policy reforms followed. The Education Act of 1962, which repealed the 1927 Education Ordinance, made local authorities and

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70 Theophile Ruberangeyo, et. al., "Social Protection: An Ongoing Process'. In Sharing Innovative Experiences: Successful Social Protection Floor Experiences" (2011) United Nations Development Programme at p. 335.

71 Ibid. Under this scheme, the contribution breakdown is as follows: 22.5% of the base salary of its members; government contribution of 17.5% and 5% from the military officer. The MMI covers members of the armed forces and their immediate families.

72 Rwanda Social Security Board: CBHI Scheme at https://www.rssb.rw/scheme/cbhi-scheme accessed on December 5, 2023.

73 Shriya Yarlagadda, "Growth from Genocide: The Story of Rwanda's Healthcare System," (2022) Harvard International Review available at https://hir.harvard.edu/growth-from-genocide-the-story-of-rwandas-healthcare-system/ (accessed on December 5, 2023).

74 Dean E and McHenry, Jr, "Ujamaa Villages in Tanzania" (1981) Scandinavian Institute of African Studies, Uppsala available at https://www.diva-portal.org/smash/get/diva2:274867/-FULLTEXT01.pdf (accessed on December 11, 2023.)

75 Chediel et al, (2000), "Private and community schools in Tanzania (Mainland)" International Institute for Educational Planning/UNESCO at p.9.

communities responsible for the provision of primary education and the construction of primary schools.[76] In 1967, the government introduced the Education for Self–reliance policy which entailed the introduction of Universal Primary Education (UPE); mandatory registration of both public and private schools; and nationalization of voluntary agency schools.[77]

Tanzania put in place numerous regulatory measures to ensure government oversight of provision of education services by private actors. For instance, under the Education Act in 1978, it became a legal requirement for owners and managers of schools to obtain approval from the Minister of Education and Commissioner of National Education respectively prior to establishing schools.[78] The Inspectorate Department in the Ministry of National Education was established.[79] The Commissioner of National Education was empowered to approve school fees for public and private schools.[80]

From the mid-1980s to the 1990s, the government introduced a macro-policy following the adoption of the Structural Adjustment Programs (SAPs) that liberalized the economy. This resulted in an increased role of the private sector in education, due to relaxation of the restrictions for private actors, and the introduction of cost-sharing in public schools.[81] However, although the Ministry of Education and Culture retained the authority to regulate fees in both public and private schools, the parents resented the new cost-sharing policy that required them to pay the newly re-established tuition fees as well as other user fees.[82] In addition, there were concerns about the variation in fees charged by private schools with some charging fees as high as Tshs. 1million per year with the formal authorization of the Commissioner.[83]

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[76] Ibid, p. 23. However, even with the nationalization, it was still possible to operate private schools in the communities such as international and Koranic schools.
[77] Ibid, p.23
[78] Ibid, p. 26.
[79] Ibid.
[80] Ibid.
[81] Lassibille et al, supra at p.5.
[82] Chediel et al, supra, at p.10 and 13. The amount of school fees paid was per year and it depended on the nature of the school. For instance, in 1999, the annual school fees structure was set as follows: Kiswahili language government primary schools – Tshs. 2,000; English language government primary schools – Tshs. 25,000; government secondary day schools – Tshs. 40,000; government secondary boarding schools – Tshs. 70,000; private secondary day schools – Tshs. 105,000; private secondary boarding schools – Tshs. 130,000. At the time US$ 1 was equivalent to Tanzanian shillings 800.
[83] Ibid.

In 2001, Tanzania reintroduced free primary education and in 2015, it abolished payment of school fees from pre–primary to lower secondary levels in public schools.[84] The country currently implements a hybrid system of education delivery. It has Government (public) schools (maintained and managed by the local authorities); grant-aided schools (including all schools owned by communities but receive grant in aid from government); and non-government (schools wholly owned and maintained by a person, body of persons or any institution other than the government).[85]

On the health front, after independence, the Tanzanian government took full responsibility for providing health care services for its citizenry. An elaborate healthcare system from the local to national level was developed[86] and it was cemented by the 1967 Arusha Declaration which sought to ensure access to health care for all persons. Ten years later, the government undertook a major radical reform in health service delivery. 1n 1977, the government enacted the Private Hospitals (Regulation) Act which provided for free health services and banned private health service provision, especially for-profit services.[87]

In the 1980s, the country experienced some economic downturn triggering reforms in the health service provision under the SAPs. In 1990, the first National Health Policy was adopted calling for private health facilities to complement public health facilities and government promotion and control of private health facilities to ensure that they effectively serve the communities. The policy proposals were reduced into law by the Private Hospitals (Regulation) (Amendment) Act, 1991, which lifted the ban on for-profit private health facilities.[88] This favorable policy and legal environment under the context of liberalization of the health sector laid the foundation for the growth of the private sector in health service delivery.[89] It was coupled with the introduction of cost-sharing in public health facilities in the

[84] The World Bank, 'New Financing to Support Tanzania in Providing Fee-free Quality Education for Millions of Children,' (2017) at https://www.worldbank.org/en/news/press-release/2017/05/23/new-financing-to-support-tanzania-in-providing-fee-free-quality-education-for-millions-of-children (accessed on December 11, 2023.)

[85] See Sections 2 and 31 of the National Education Act, Cap 353, as amended.

[86] Tibandebage et al, 'Private Sector Development: The Case of Private Health Facilities,' (2000) Economic and Social Research Foundation.

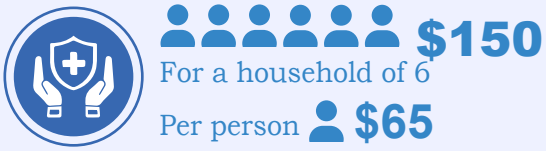
[87] Kitole FA. et al, "Equity in the public social healthcare protection in Tanzania: Does it matter on household healthcare financing?" (2023) International Journal for Equity Health.

[88] The United Republic of Tanzania, Private Hospitals (Regulation) (Amendment) Act, 1991.

[89] Kitole supra.

form of user fees between 1991 and 1995.[90] However, the user fees affected access to health services by the rural, poor and marginalized households. In response, the government introduced the Community Health Fund in 1996, an insurance plan by the government targeting the poor, informal sector workers and rural populations.[91] Eventually, the government introduced the National Health Insurance Fund in 1999, with operations commencing in 2001, which was closely followed by the introduction of the private health insurance schemes in 2002.[92]

To date, health insurance schemes have undergone various reforms. For instance, the community health fund registered dismal performance prompting government to introduce the Social Health Insurance Benefit (SHIB) in 2007 – relying on both public and private health providers.[93] In 2015, the National Health Insurance Fund Act was also enacted to expand health insurance coverage for the formal sector. This notwithstanding, coverage has remained low with more than three-quarters of the population not covered under insurance.[94] Recently, the government enacted the Universal Health Insurance Act, 2023 that provides for mandatory health insurance proposing an annual premium contribution of $150 for a household of six or $65 per person.[95]

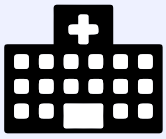


However, these figures appear to be on the higher side as research indicates that the greater proportion of the population cannot afford a contribution of **$4**.[96]

The private health actors play a key role in influencing health policy implementation. For instance, early this year, the government paused the implementation of new rates for the National Health Insurance Fund (NHIF) due to backlash from private health service providers who argued that they would

[90] Ibid.
[91] Ibid.
[92] Ibid.
[93] Amani Thomas Mori, "Mandatory health insurance for the informal sector in Tanzania - has it worked anywhere!" (2023) National Library of Medicine.
[94] Ibid.
[95] Ibid
[96] Ibid.

result in losses given their operational costs.[97] According to the Health Facility Register, as of 2023, 61.8% of the health facilities in the country are owned by the private sector (faith based organizations, private for-profit entities and non–government organizations) while 38.2% are publically operated.[98]



61.8% owned by private sector

38.2% are publically operated

[97] The East African, Tanzania makes U-turn on reduced NHIF rates after private sector protests, Friday January 05 2024 at https://www.theeastafrican.co.ke/tea/business/tanzania-u-turn-reduced-nhif-rates-private-sector-protests-4483014 accessed on February 15, 2024.

[98] United Republic of Tanzania, Ministry of Health, Health Facility Registry.

3

Conceptual framework

3. Conceptual framework

During the Washington Consensus in the 1980s – 1990s, numerous African countries adopted market based structural reforms or 'conditionalities' under the SAPs. These ranged from privatization, trade liberalization, promotion of foreign direct investment to deregulation.[99] In the health sector, this manifested through introduction of user fees in health facilities, facilitating and promoting private sector participation in the provision of healthcare and establishment of contributory insurance schemes.[100] These policies, particularly deregulation, coupled with reduced public investment in both health and education sectors over the years and cost sharing have laid fertile ground for commercialization of public services in Africa.[101]

A key question, explored by scholars in the context of the Millennium Development Goals (MDGs), was whether governments should strengthen their provision of public services or create an enabling environment for private actors through risk reduction measures.[102] This debate remains highly relevant to date. The participation of private sector in realisation of development goals is deeply anchored within the 2030 Sustainable Development Goals (SDGs) Agenda and its implementation framework.[103] In what Gabor has named the "Wall Street Consensus", development has been opened up to private finance under the language of 'partnerships' with governments.[104] Derisking is a central feature. Its implemented through policy or regulatory measures (creating an enabling legal, policy and institutional environment for private finance and reducing regulatory barriers) and financial incentives such as subsidies, tax incentives and guarantees for instance under PPP arrangements.[105] Thus the role of States has shifted from

[99] Daniela Gabor, "The Wall Street Consensus" (2021), Volume 52, Issue 3, Development and Change, International Institute of social Studies.
[100] Ibid.
[101] The African Commission on Human Rights and Peoples Rights General Comment No. 7, para 3.
[102] Kate Bayliss and Tim Kessler, "Can Privatization and commercialisation of public services help achieve the MDGs? An Assessment" (2006) International Poverty Centre, United Nations Development Programme (UNDP) Working paper No. 22.
[103] Celine Tan, "Private investments, public goods: Regulating markets for sustainable developments" (2022) European Business Organization Law Review.
[104] Gabor, supra.
[105] Ibid.

regulators of private actors in the Post Washington Consensus[106] to enablers of provision of services by the private sector.[107]

As with liberalization, international financial institutions are also key proponents of the commercialization agenda. Through World Bank's Cascade Approach for instance, it has taken on an ambitious strategy of mobilizing private finance to meet the financing gap for realizing the SDGs.[108] This is demonstrative of an increasing shift in the role of international organisations from funding social services to 'brokers' for private finance for SDGs, preoccupied with promoting private sector participation in development interventions.[109] This approach has permeated domestic policies on health and education service delivery, largely due to influence of IFIs through their technical advice and lending terms.

It is within this global context that this study looks at the commercialization of public services. The study adopts the definition of commercialization by Bayliss as "the process of transforming a transaction into a commercial activity, in which goods or services acquire monetary value."[110] Often invoked from a revenue generation perspective, it is typically aimed at expanding the financial resources available for delivery of services.[111] In this study, market mechanisms of this nature, through which public services have been liberalized and commodified for profit making, are discussed under the broad umbrella of commercialization.

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[106] This is a period following the Washington Consensus characterized by attempts to correct the market failures through increased regulation and poverty alleviation programs. See United Nations General Assembly, 'Report of the Special Rapporteur on extreme poverty, Philip Alston' A/73/396 at para 8.
See also, Ziya Onis and Fikret Senses. "Rethinking the emerging Post-Washington Consensus' (2006) Development and Change 36 (2) cited in Gabor, ibid.

[107] See also, Bayliss and Kessler, supra.

[108] See, Tito Cordella, "Optimizing Finance for Development" (2018), World Bank Group, Policy Research Working Paper 8320. See also, United Nations General Assembly, 'Report of the Special Rapporteur on extreme poverty, Philip Alston' A/73/396 at para 20.

[109] Celine Tan, supra.

[110] See Bayliss and Kessler, supra.

[111] Although both are market based approaches underpinned by similar economic arguments, commercialization and privatization are not synonymous. "Broadly speaking, commercialization addresses a revenue problem, while privatization addresses either long-term investment constraints, governance weaknesses or both. In some cases, privatization may be adopted as an instrument to achieve commercialization itself – that is, to eliminate fiscal losses stemming from public subsidies." See Bayliss and Kessler, ibid.

Commercialization in the context of health and education services manifests in different ways in Africa presently. In the health sector, initiatives couched in the language of 'partnerships' between the public and private sector are dominant.[112] In the education sector, interventions typically include private actors taking over public schools or undertaking certain functions in public schools under contract with States.[113] In this study, private actors refers to all non-State actors including faith based actors and private not for profit entities.[114]

This study adopts a distinction between 'private provision' and 'commercialization' made by the African Commission on Human Rights and Peoples Rights in General Comment No. 7 in the context of social services delivery. The Commission noted that the participation of private actors in service delivery need not necessarily result in the relegation of State obligations to private actors.[115] The Abidjan Principles on the Right to Education elaborate that private provision of education should supplement rather than diminish or substitute public provision and not negatively affect the right to education.[116]

For the purposes of this study, a human rights framework is used to analyse and interpret the findings. It will be helpful is analyzing the extent to which the relegation of the role of the State to deliver and finance public services to the private sector is affecting the realisation of the right to health and education in East Africa.

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[112] Sonia Languille, "Public-private partnerships in education and health in the global South: a literature review", *Journal of International and Comparative Social Policy*, vol. 33, No. 2 (2017).

[113] Antoni Verger et. al, "Multiple paths towards education privatization in a globalizing world: a cultural political economy review", *Journal of Education Policy*, vol. 32, No. 6 (2017) cited in United Nations General Assembly, 'Report of the Special Rapporteur on extreme poverty, Philip Alston' A/73/396.

[114] World Health Organization (WHO) defines private actors to include faith-based and other nongovernmental non-profit organizations and individual health-care entrepreneurs, both formal and informal, to private for-profit firms and corporations. See, WHO, "Strengthening the Capacity of Governments to Constructively Engage the Private Sector in Providing Essential Health-Care Services" (2010) WHA 63.27, Agenda Item 11.22 available at https://iris.who.int/bitstream/handle/10665/3101/A63_R27-en.pdf?sequence=1&isAllowed=y (accessed on March 31, 2024).

[115] The African Commission on Human Rights and Peoples Rights General Comment No. 7, para 12-14.

[116] Abidjan Principles on the Right to Education, para 48.

4

Methodology

4. Methodology

This study is investigating the human rights impact of commercialization of public services in the East African region with a focus on Uganda, Kenya, Tanzania and Rwanda. It was conducted using qualitative methods. Specifically, it entailed a comprehensive desk review covering the health and education related laws, policies and government reports and surveys of the study countries, reports of treaty bodies, international organisations, NGOs and CSO organisations. The data collected was analyzed using a human rights framework to understand the impact of increased involvement of private actors on the enjoyment of the rights to education and health.

5

Legal and policy framework relevant to commercialization of social services in East Africa

5. Legal and policy framework relevant to commercialization of social services in East Africa

This section analyses the legal and policy framework relevant to the commercialization of public services in the selected East African countries. It discusses the international and regional human rights obligations enshrined under the legal instruments ratified by the respective countries. At a domestic level, it analyses the laws and policies governing the provision of education and health services by private service providers including the current regulatory framework.

5.1. International and Regional Human Rights Obligations

The study countries are parties to numerous international and regional human rights instruments which lay down obligations with respect to provision of social services such as education and health care. The focus for this research is the International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of the Child (CRC), the African Charter on Human and Peoples' Rights (ACHPR) and the African Charter on the Rights and Welfare of the Child (ACERWC) and the respective General Comments that have been developed thereunder.

Article 13(2) of the ICESCR makes provision for compulsory and free primary education and requires governments to progressively introduce free secondary and higher education.[117] Article 12 (1) of the ICESCR also guarantees the right to enjoy the highest attainable standard of physical and mental health.[118] With respect to obligations of the State, the tripartite duties to respect, protect and fulfill rights apply to education and health services.[119] General Comments No. 13 and 14 by the Committee on Economic, Social and Cultural Rights (CESCR)

[117] Article 13 and 14, International Covenant on Economic, Social and Cultural Rights (ICESCR), 16 December 1966.

[118] Article 12 (1) ICESR.

[119] The obligation to protect entails ensuring that third parties do not interfere with the enjoyment of these rights. The obligation to respect requires the state to refrain from interfering with the enjoyment of the rights while the duty to fulfill requires the State to facilitate enjoyment of the right and to provide (take measures to ensure realisation of the rights). See UN Committee on Economic Social and Cultural Rights General Comment No. 13: The Right to Education (Article 13) at para 47 and UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) at para 33.

developed essential elements of the rights to education and health services respectively – availability, accessibility, acceptability and adaptability (education) or quality (health), referred to as AAAA/AAAQ Framework (Table 3).[120]

Table 2: AAAA/AAAQ Human Rights Framework

Availability	Existence of health facilities and education institutions of a sufficient quantity which are available to the whole population. Ensure availability of good quality drugs and equipment, clean and sanitary premises, and adequately trained health professionals and teaching staff.
Accessibility	Physical accessibility: health and education services which are in a reasonable distance from communities. Economic accessibility: health and education services which are affordable for all regardless of whether they are publically or privately provided. Primary education must be affordable to all for free. Non-discrimination: education and health services accessible by all, especially vulnerable groups.
Acceptability	Education services which are relevant, appropriate and respectful of the culture of individuals and communities, including vulnerable and minority groups. Health services which are respectful of cultures and medical ethics.

[120] Ibid. at para 6 and para 12 respectively.

Quality (right to health)	Health services of good quality (skilled health professionals, safe, clean and sanitary premises, safe drugs and equipment).
Adaptability (right to education)	Education which is flexible and adaptive to the changing needs of the society and learners.

The term "free of charge" contained in Article 13 (2) of the ICESCR has been interpreted to imply accessing primary education without any charge to children and their parents or guardians.[121] As such, it prohibits additional school charges imposed by the government, the local authorities or the school, and other direct costs, which constitute disincentives to the enjoyment of the right and may jeopardize its realization.[122]

With regard to private provision of education, Article 13(4) of ICESCR protects the right of non–state actors to found and operate schools provided they comply with the established minimum education standards established by the State. CESCR General Comment No. 14 also requires that health services, whether delivered by public or private health facilities, are made affordable and provided on the basis of the principle of equity to ensure that poor households are not disproportionally burdened with health bills. Specifically, on private provision, CRC General Comment No. 16 and CESCR General Comment No. 24 require States to protect their populations from violation of rights by third parties.[123] The duty is of primary importance when considering States' obligations with respect to private providers of social services. States are mandated to undertake all "necessary, appropriate and reasonable measures to prevent business enterprises from causing or contributing to abuses of children's rights."[124] Such measures range from passing,

[121] Committee on Economic Social and Cultural Rights General Comment No. 11: Plans of Action for Primary Education (Article 14). Para. 7.
[122] Ibid.
[123] Committee on the Rights of the Child, General comment No. 16 (2013) on State obligations regarding the impact of business on children's rights, para 28. Also see Committee on Economic, Social and Cultural Rights General Comment No. 24 (2017) on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities, paras 14 – 16.
[124] General Comment No.16, Ibid.

monitoring and enforcing of laws and regulations as well as adopting policies highlighting the potential impact of business enterprises on children's rights. A State is therefore responsible for infringements of children's rights caused or contributed to by business enterprises where it fails to put in place the requisite measures to prevent and remedy such violations.[125]

On private health provision, the CESR in its General Comment No. 14 indicated that the government obligation to ensure the availability, accessibility, acceptability of quality health services, facilities and supplies should not be compromised by commercialization.[126] The Committee elaborated further in General Comment 24 that private health-care actors should be strictly regulated and "prohibited from denying access to affordable and adequate services, treatments or information."[127]

At a regional level, ACHPR and ACERWC guarantee the right to education and health.[128] The recent General Comment No. 7 by the African Commission on Human and Peoples Rights is instructive on the obligations of African States with respect to private provision of social services.[129] The General Comment drew on other existing principles including the UN Guiding Principles on Business and Human Rights and the Abidjan Principles on the Right to Education.[130] It underscores the non–commercial character of social services and highlights how the ongoing "commercial interests in Africa are transforming social services into private commodities."[131] It points out that the growing trend of commercialization undermines the object and purpose of the African Charter by viewing and treating social services as commercial products tagged with a price rather than essential preconditions for the enjoyment of human rights on the continent.[132]

The African Commission thus calls for effective regulation, including through adoption of regulatory standards, monitoring and evaluation frameworks as well

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[125] Ibid.
[126] General Comment No. 24, at para 21.
[127] Ibid.
[128] Article 16 and 17 of the ACHPR and Articles 11 and 14 of the ACERWC.
[129] General Comment No. 7 on State Obligations Under the African Charter on Human and Peoples' Rights in the Context of Private Provision of Social Services.
[130] Ibid. at para 7.
[131] African Commission on Human and Peoples' Rights, General Comment 7: State obligations under the African Charter on Human and Peoples' Rights in the context of private provision of social services, para 11.
[132] Ibid.

as enforcement and accountability mechanisms, as a central pillar of the State's obligation to protect human rights.[133] This entails regulation of both foreign and local companies as well as other private actors to prevent them from abusing people's rights and ensuring that their actions support as opposed to undermining the enjoyment of economic and social rights such as education and health.[134]

1.2. Domestic Legal and Policy Framework

The foregoing international and regional instruments require the governments of the study countries to take appropriate measures to ensure that private service providers support rather than undermine the enjoyment of human rights. This subsection analyses the current legal and policy framework to determine the extent to which effective monitoring, supervision and regulation of private actors who participate in service provision in the health and education sectors is embedded therein.

Uganda

A key starting point for this discussion is Article 20 (2) of the Constitution of Uganda 1995 which requires all persons to respect human rights. This applies to private actors in health and education delivery. On the education front, Objective XVIII of the National Objectives and Directive Principles of State Policy of the Constitution, permits individuals, religious bodies and other non-governmental organizations to found and operate schools in Uganda. The Education (Pre-Primary, Primary and Post-Primary) Act, 2008 whose objective is to promote partnership with the various stakeholders in providing education services and it provides mechanisms for establishing private schools among others.[135] Under the Act, private schools include for-profit and nonprofit schools as well as international institutions.[136] It also lays down procedures through which non–state actors can start and operate schools.[137] The Act also empowers the Minister of Education to regulate the fees charged by any school.[138]

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[133] Ibid, para 43.
[134] Ibid, para 43.
[135] Section 1 (e) of the Education (Pre-Primary, Primary and Post-Primary) Act, 2008.
[136] Ibid, Section 6 (c).
[137] Education Act 2008, supra, Part VII.
[138] Ibid, Section 57 (g).

In 2014, the Ministry of Education and Sports issued the Guidelines for Establishing, Licensing, Registering and Classification of Private Schools/Institutions in Uganda. The purpose of the Guidelines is to guide persons intending to start the school. Read together with the Act, it is envisaged that a person or organization can start operating a school before finalizing the process of licensing and registration.[139]

On education financing, Section 4(3) of the Education Act, 2008 lists school fees as one of the sources of financing for education. However, in UPE and USE schools in particular, Section 9 of the Act outlaws the charging of school fees and costs in UPE and USE schools. The enactment of this provision was on the basis that upon the introduction of UPE and USE, the government would meet all the financial needs of the school – infrastructure, teaching staff and operation funds for the schools. Interestingly, the same provision permits voluntary contributions by parents to respond to emergencies or urgent matters.[140]

UGX 10,400/=
annually for administrative and utility expenses

Also, the Regulations for School Management Committees (SMCs) allow schools in the jurisdiction of an urban area to charge UGX 10,400/= annually or as prescribed for administrative and utility expenses.[141] This appears to be at odds with the recent cabinet directive which banned the inclusion of any related SMC costs in the school fees structure.[142]

Based on the stance of the government of promoting partnership under the Education Act, the Ministry of Education and Sports engaged private schools under a PPP arrangement in the implementation of the USE program in 2007. The PPP scheme commenced with funding from the World Bank, however, it was phased out a decade later.[143] A key challenge with the financing arrangement was

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[139] Under Sections 31, 32 and 34 of the Education Act are of the effect that proprietors of private schools can obtain a provisional licence to run a school while awaiting completion of the registration process.

[140] See Section 9 (2) of the Act.

[141] Second Schedule of the Education Act, 2008, Regulation 15 (5) of the 58, 59 The Education (Management Committee) Regulations.

[142] Daily Monitor, "Government to close schools over high fees' (2024) available at https://www.monitor.co.ug/uganda/news/national/govt-to-close-schools-over-high-fees--4538742 (accessed on February 29, 2024).

[143] World Bank, "Uganda Secondary Education Expansion Project: Project Information Document" (2018) at p. 18.

highlighted in Initiative for Social and Economic Rights (ISER) & Ors v Attorney General & Ors.[144] The court found that the financial allocation to private schools under the USE program was much lower than funding provided to government aided schools. This affected the quality of education received by learners in the former schools.

The Constitution does not contain an explicit provision on founding and operating of private health facilities. However, this freedom can be inferred from Objective XIV of the Constitution which requires the State to ensure that all Ugandans enjoy rights and opportunities and access health services among other services. Article 40(2) also recognizes the right of every person in Uganda to practice his or her profession and to carry on any lawful occupation, trade or business such as private health facilities.

In its first National Health Policy, the government adopted the Uganda National Minimum Health Care Package (UNMHCP).[145] It committed to allocate and spend an increasing proportion of its annual health budget (both domestic and external resources) to ensure provision of the package.[146] In meeting this goal, the position of the government is to partner with and promote the growth of the private sector in health service delivery in various ways.[147] Firstly, assisting the private sector to expand their operations to areas which are not effectively served by public facilities (as opposed to setting up competing public services).[148] Secondly, exploring alternative options for improving efficiency within the public health sector such as contracting out clinical and non-clinical services.[149] Thirdly, offering incentives that would attract private health services to all parts of the country.[150] The Ministry of Health also committed to regulate the operations of the

[144] High Court Civil Suit No. 44 of 2021.
[145] Ministry of Health, First National Health Policy. The package includes Control of Communicable Diseases (malaria, HIV/ AIDs, Tuberculosis), Integrated Management of Childhood Illness, Sexual and Reproductive Health and Rights (Essential Ante-natal and Obstetric Care, Family Planning, Adolescent reproductive health), Other Public Health Interventions (immunization, epidemics improving nutrition etc).
[146] Ibid.
[147] Ibid. The private sector in health is further described to consist of NGOs (facility and non-facility -based), private practitioners, the traditional healthcare system of traditional healers and midwives, and the private pharmaceutical sector.
[148] Ibid.
[149] Ibid.
[150] Ibid.

private sector and to monitor and evaluate the effect of privatization in the health sector.[151] This has not been done to date.

This policy environment laid the fertile ground for the growth of the private sector in health. In its Second National Health Policy (2010), the focus shifted to providing financial incentives to the private sector for instance through PPP arrangements under which public resources are availed to the private sector to boost their expansion, especially in areas without public health facilities.[152] This has been bolstered by the adoption of the National Policy on Public-Private Partnership in Health which has concretized the central role of the private sector in numerous aspects of health service delivery.[153]

With regard to healthcare practitioners, the Uganda Medical and Dental Practitioners Act creates a Council which is mandated to regulate the operations of private health facilities and the professional conduct of medical and dental practitioners.[154] The Act permits registered and licensed medical or dental practitioners operating private health facilities to levy "reasonable charges" for their services and drugs which they are entitled to recover in courts of law.[155] The issue of high charges levied by private health facilities has been a subject of litigation before courts of law following numerous calls to the Ministry of Health to regulate the costs of private healthcare (Annex).

Kenya

Article 43 of the Constitution of Kenya guarantees a range of social and economic rights including the rights to health and education. Article 53 (1) (b) provides for the right of children to free and compulsory basic education. The country has adopted policy and legislation governing its health and education sectors which encompasses the aspect of regulation of private service providers.

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[151] Ibid.
[152] Ministry of Health, Second National Health Policy, 2010. See also, Initiative for Social and Economic Rights (ISER) 2019, "Achieving Equity in Health: Are Public Private Partnerships the Solution?" at p. 7.
[153] Ibid, p. 17 – 19.
[154] Uganda Medical and Dental Practitioners Act Cap 272, Sections 3, 17, 27 & 29.
[155] Ibid, Section 42.

One of the key objectives of the Kenya Health Policy is to strengthen collaboration with the private sector.[156] As a result, one of the Policy imperatives is to create an enabling environment for increased private sector and community involvement in health services provision and financing.[157] The private sector is viewed as a complementary to the public sector in terms of increasing geographical access to health services and the scope and scale of services provided.[158] The government plans to strengthen its collaboration and creation of favourable environment for the private sector through; development of a Public Private Partnership in Health (PPPH) policy framework; establishment of appropriate legislative frameworks and guidelines to facilitate and regulate the private sector in line with existing laws and regulations; work with the private sector to reform incentive mechanisms to attract registered private health practitioners to the under-served and difficult to reach areas.[159]

The Health Act No. 21 of 2017 permits private actors to operate in all spheres of the health sector provided they are licensed by appropriate authorities and are in compliance with the established standards.[160] While international human rights law requires private actors to supplement efforts of the public sector, the Act considers the public and private health services and facilities as complementary to each other in the provision of comprehensive and accessible health care.[161] In line the government's strategy of promotion of the private sector in health service delivery, the Act empowers the national and county governments to enter into public-private partnerships to establish and deepen health service provision.[162] The partnership is subject to the provisions of the Public Private Partnership Act No. 14 of 2021 (Box 3 below).[163]

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[156] Ministry of Health, Kenya Health Policy 2014–2030, Nairobi, 2014 at p.4.
[157] Ibid, p.18.
[158] Ibid, p.28.
[159] Ibid, p. 35.
[160] Section 89(1) of the Health Act No. 21 of 2017.
[161] Ibid, Section 88(2).
[162] Ibid, Sections 23, 88 (1) and 92.
[163] Ibid, Section 92(1) & (2). Also see ALSO Section 3 of the Public Private Partnerships Act No. 14 of 2021. The objects of the Act are to— (a) prescribe the procedures for the participation of the private sector in the financing, construction, development, operation or maintenance of infrastructure or development projects through public private partnerships.

The Act has also explicitly provided for the involvement of the private sector in the implementation of the national health insurance scheme. This is in two ways: providing for regulation of all health insurance providers and utilizing private health providers as a way of reducing the burden on the public health system.[164] The Act also recognizes the practice of traditional medicine in the country. It requires the state institution responsible for the regulation of traditional medicine to register and maintain a register at both national and county levels; licensing and setting of minimum standards for the practice of traditional medicine.[165]

In line with Article 43 of the Constitution, the Act guarantees the right to emergency treatment from all health facilities, including private ones. This includes hospital care, stabilizing the health status of the individual or arranging for referral in cases where the health provider of the first call does not have facilities or capability to stabilize the patient.[166]

The Medical Practitioners and Dentists Act governs licensing and inspection of private health practitioners and health facilities.[167] It is a requirement for all persons who run medical and dental practice to hold a practicing licence under this law.[168] The Cabinet Secretary for Health is responsible for regulating fees charged by medical and dental practitioners.[169] In the exercise of these powers, the Cabinet Secretary issued the Medical Practitioners and Dentists (Professional Fees) Rules, 2016 which set out the minimum and maximum professional costs chargeable by medical and dental practitioners for various medical and dental procedures.[170] Failure to comply with these Rules amounts to professional misconduct.[171]

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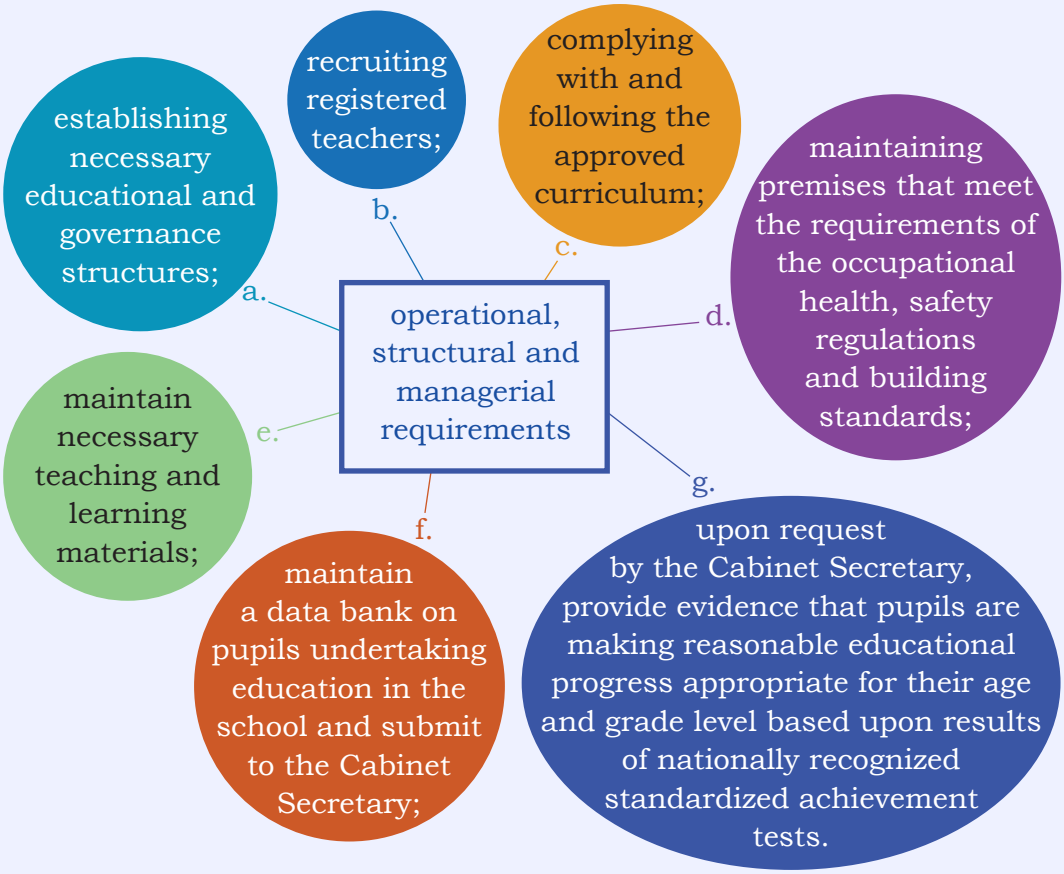
[164] Health Act No. 21 of 2017, Section 86(1) (b) & (2) (b).
[165] Ibid, Section 75.
[166] Ibid, Section 7.
[167] Section 2, the Medical Practitioners and Dentists Act. The Act defines private practice to mean "giving medical, surgical or dental advice, attendance or performing an operation, or engaging in radiological or clinical laboratory medicine, for a fee, at a facility that is not for the Government."
[168] Ibid, Section 5.
[169] Section 23 of the Medical Practitioners and Dentists Act cap 253, empowers the cabinet secretary in consultation with the council to issue various rules to guide the implementation of the Act.
[170] Regulation 3 of the Medical Practitioners and Dentists (Professional Fees) Rules, 2016.
[171] Ibid, Regulation 5.

The recently passed Social Health Insurance Act established the Social Health Insurance Fund.[172] Kenyan households and persons who ordinarily reside in the country are required to make contributions while the State will contribute on behalf of households which cannot afford.[73] The Act permits Social Health Authority to contract any healthcare service providers, public or privately owned, to provide health insurance.[174]

The basic education legal regime in Kenya offers a favourable environment to the private sector involved in basic education. Basic Education Act No. 14 of 2013 is the primary legislation governing operation of schools in Kenya. It provides for two categories of schools largely: public schools – established, owned or operated by the Government including sponsored schools; and private schools – established, owned or operated by private individuals, entrepreneurs and institutions.[175] A private school is defined as a school established, owned or operated by private individuals, entrepreneurs and institutions.[176]

Any person is allowed to set up and operate a private basic education institution provided that they comply with several operational, structural and managerial requirements. These include (a) establishing necessary educational and governance structures; (b) recruiting registered teachers; (c) complying with and following the approved curriculum; (d) maintaining premises that meet the requirements of the occupational health, safety regulations and building standards; (e) maintain necessary teaching and learning materials; (f) maintain a data bank on pupils undertaking education in the school and submit to the Cabinet Secretary; (g) upon request by the Cabinet Secretary, provide evidence that pupils are making reasonable educational progress appropriate for their age and grade level based upon results of nationally recognized standardized achievement tests.[177]

[172] The Social Health Insurance Act, Sections 26 and 27 and the Social Health Insurance (General) Regulations, 2023, Regulations 16 (1) and 17 (1).
[173] The Social Health Insurance Act, Sections 27 (2).
[174] The Social Health Insurance Act, Section 31 and Section 2 of the Health Act, No. 21 of 2017.
[175] Basic Education Act No. 14 of 2013, Section 43 (1).
[176] Ibid, Section 2.
[177] Ibid, Sections 49, 50 and 52 (1).



There are mechanisms to ensure that the private schools are complying with the established education standards and other operational requirements. For instance, the County Education Board, in consultation with the Teachers Service Commission, is mandated to assess the quality and performance of private schools, including teachers and non-teaching staff, their educational programs and the school instructional materials and to inspect the school premises.[178] Schools are allowed to operate under the provisional registration arrangement, similar to Uganda's, for two years until they obtain final registration upon meeting all the requirements.[179]

The Act permits the conversion of public basic education institutions into private schools upon consultation with the National Education Board and approval by the

[178] Ibid, Section 52 (2).
[179] Ibid, Section 50 (3)

Cabinet Secretary.[180] Interestingly, it is silent on the reverse – conversion of private schools into public ones. It can be argued that this amounts to supplanting or replacing of public schools by private actors or institutions.[181]

Generally, public schools are generally prohibited from charging tuition fees.[182] The exception to this is non-citizens may be required to pay tuition fees and some non-tuition charges may be levied by public schools with the approval by the Cabinet Secretary in consultation with the County Education Board.[183] This notwithstanding, school fees are not recognized as one of the primary sources of financing for basic education in the country, unlike the Ugandan position.[184]

Rwanda

The Rwandan Constitution 2003 guarantees the right to education.[185] It stipulates that primary education is free at primary level in public schools as well as government aided schools on conditions stipulated in law. Law N° 010/2021 of 16/02/2021 Determining the Organization of Education highlights the various categories of institutions which can provide basic education services. Article 8 of the Act provides for categories of schools that include: public, government subsidized and private schools.[186] For government subsidized schools, the Government and its stakeholders enter into an operating agreement which sets out the role and responsibilities of each party.[187] Private education institutions are required to comply with education standards in Rwanda and are subject to regular inspection.[188]

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[180] Ibid, Section 43 (2).
[181] See for instance the Abidjan Principles on the Right to Education, para 48.
[182] Ibid, Section 29 (1). This extends to other related fees such as payment of holiday tuition and admission fees in public schools. See Sections 32 and 37.
[183] Ibid, Section 29 (2).
[184] Ibid, Section 86.
[185] Articles 20 of the Rwandan Constitution.
[186] Law N° 010/2021 of 16/02/2021 Determining the Organization of Education, Article 10. The Act defines government–subsidized schools as schools that are constructed by the government on land owned by individuals, faith-based organizations, national and international non-government organizations or vice versa or schools constructed in collaboration between the government and the non–state actors.
[187] Ibid.
[188] Article 11 of defines private schools to mean institutions established by an individual, a legal association of persons, a faith-based organization, a national non-governmental organization, an international non-governmental organization recognized in Rwanda or an international education institution or another country.

With regard to tuition and other costs, Article 6 of the Act requires parents to provide for their children "the necessary means" for their education. This has monetary implications. The same provision also mandates parents to contribute to the school feeding program for their children at school.[189] As highlighted in Section one of this study, the Rwandan government issued a fees structure for primary and secondary public and subsidized schools as well as a school feeding plan in which costs are split between the government and parents.

For secondary education specifically, Article 41 of the Law N°23/2012 of 15/06/2012 Governing the Organization and Functioning of Nursery, Primary and Secondary Education sets various obligations on the part of the State. It obligates the Minister in charge of Education to determine the school fees to be paid by parents in both public and government-subsidized schools. In private schools, it is a requirement that fees are determined according to an action plan examined by the School General Assembly and submitted to the District for approval. To cover costs of secondary education for learners from poor households, Article 41 requires the establishment of a District Education Fund by a Presidential Order.[190]

The above laws are reflective of the Rwandan government's position in its Education Policy 2003. The Policy acknowledges the importance of participation

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[189] Lliza Ange "Public School Fees capped at $85 to meet 'Education for All' national goal" Rwanda Today, September 21, 2022 at https://rwandatoday.africa/rwanda/news/public-school-fees-capped-at-85-to-meet-education-for-all-national-goal-3956612 (accessed on February 01, 2024). See also, Rwanda Ministry of Education, Rwanda School Feeding Operational Guidelines Summary at p. 6.

[190] In 2015, the President exercised the powers under the Act and issued the Presidential Order determining Modalities for Supporting Public Schools, Government-Subsidized Schools and Private Schools to meet their Objectives. It provided modalities for supporting public, government-subsidized and private schools. For subsidized schools, the support included building new schools and rehabilitating schools in poor or damaged condition; equipping the schools with working materials; recruiting the school staff and paying their remuneration; enrolling students; developing curricula and other necessary materials; following up the teaching, learning and the management of the schools; determining mechanisms related to knowledge assessment; and motivating parents to participate in the development of the school. For private schools, support included developing curricula and other necessary materials; supervising the teaching, learning and management of the schools; determining mechanisms related to knowledge assessment; and motivating parents to participate in the development of the school.
See Government of Rwanda, Presidential Order determining Modalities for Supporting Public Schools, Government-Subsidized Schools and Private Schools to meet their Objectives, Presidential Order No. 116 of 2015.

of different partners in education service delivery including the government, parents, communities, donors, the private sector, NGOs and civil society.[191] The government indicates its aim of partnering with donors and the private sector in education using key strategies such as encouraging private actors to operate schools and absorb some of the numbers, particularly in secondary education.[192] With respect to financing of education, although the government commits to finance education at all levels, it also envisages that other stakeholders including the private sector, civil society, religious organizations, communities, donors and beneficiaries will also play a role.[193]

The National Examination and School Inspection Authority (NESA) is responsible for inspecting all public, government–subsidized and private schools to monitor the implementation of standards.[194] It sets standards for accreditation of private basic education schools, monitors the implementation of standards and ensures the quality of education services in all schools which provide basic education.[195]

With regard to the health sector, the Rwandan Constitution guarantees the right to health. The country has passed various regulations governing the provision of private healthcare. Law No 45/2012 of 14/01/2013 on Organization, Functioning and Competence of the Council of Pharmacists and Law N°44/2012 of 14/01/2013 on the Organization, Functioning and Competence of the Medical and Dental Council require pharmacists and practitioners to register with the respective councils to qualify to provide services.[196] However, both laws are silent on the regulation of charges which can be levied by these professionals in private facilities.

The primary policy document, Health Policy 2015, seeks to enhance the role of private health service providers in health care delivery in Rwanda.[197] This is intended to ensure that the private sector complements the government efforts in

[191] Ministry of Education, Science, Technology and Scientific Research, Education Sector Policy, 2003, Government of Rwanda, p. 8.
[192] Ibid, p.7 and 21.
[193] Ibid, p. 21.
[194] Ibid, Article 27.
[195] Rwanda National Examination and School Inspection Authority (NESA) Overview available at https://www.nesa.gov.rw/1/about-nesa (accessed on February 20, 2024).
[196] Article 32.
[197] Ministry of Health, Health Sector Policy, 2015, Government of Rwanda at p. 5.

the delivery of health services. The policy encourages private sector involvement in both the supply of health services (including development of hospitals, clinics, diagnostic centres, education institutions, medical tourism) and the demand for health services, essentially through the health insurance system.[198] It also proposes strengthening Public Private Partnerships (PPPs) in the delivery of health services such as a Public-Private-Community Partnership between the Ministry of Health, Districts, private operators and the local community.[199]

In line with promotion of private health service provision, the Rwandan government has passed numerous policies and guidelines on provision of healthcare services by private actors. The Ministerial Instruction No. 200/03 – Governing Private Health Facilities in Rwanda lay down the requirements for authorization to open private health facilities as well as the various categories of private health facilities such as dispensaries, polyclinics, hospitals, specialized hospitals and diagnostic centres. The Private Health Facilities in Rwanda Health Service Packages, 2017 serves as a guide on the standard packages of services which private health facilities can provide at each level of the healthcare system.[200] The Private Health Facility Licensing Standards 2019 aim to protect citizens against unsafe standards, practices and low-quality health services. They indicate the requisite equipment and supplies and qualified health personnel health facilities should have. Private facilities are required to meet all the critical licensing standards and achieve at least 85% or above in the overall licensing assessment.

Rwanda runs a health insurance system governed by the Rwanda Health Insurance Policy 2010 and Law N° 48/2015 of 23/11/2015 Governing the Organization, Functioning and Management of Health Insurance Schemes in Rwanda. The schemes include public, community and commercial health insurance. Article 3 of the Act makes it mandatory for any person living in Rwanda to have health insurance. For commercial health insurance entities, the amount of premiums is determined by the contract between the insurer and the insured person, however, the maximum amount of premiums is regulated by the authority regulating the insurance business in the country.[201] The National Health

[198] Ibid, P. 22
[199] Ibid.
[200] Ministry of Health, Private Health Facilities in Rwanda Health Service Packages, Government of Rwanda, 2017 at p. 7.
[201] Article 16.

Insurance Council plays a key supervisory role over provision of health insurance including setting prices or tariffs for services provided by insurers and supervising the quality of services.[202] Rwanda Social Security Board (RSSB) is responsible for the management and operation of the Rwanda Health Insurance Fund (RAMA) and the Community-Based Health Insurance.[203] The Board is responsible for authorizing associations to carry out health insurance business.[204] It is empowered to issue guidelines on the contributions by members of insurance associations and determine the premiums to be paid to commercial insurance companies.[205]

Tanzania

The Tanzanian Constitution protects the right to access to education.[206] Provision of education services by private actors is primarily governed by the Education and Training Policy 1995 and National Education Act 1978 (as amended). The policy highlights the failure by the government to finance public education following the nationalization of education and the resultant liberalization of the sector.[207] It stipulates that financing of education is a shared responsibility between the government, communities and end–users thus it requires the government to incentivize non-State actors to the develop and establish primary and secondary schools. It specifically permits private school owners to propose and present their school fees structure for approval by the government.[208]

The National Education Act permits non–State actors to establish and operate schools. Under Section 31 of the Act, in addition to public schools, the Act provides for grant-in-aid schools and private schools (non-government

[202] Article 27 and 29 of the Law N° 48/2015 of 23/11/2015 Governing the Organization, Functioning and Management of Health Insurance Schemes in Rwanda.
[203] Ibid, Article 2(8) defines Community-based health insurance scheme as a mutual help system whereby people organize themselves collectively by paying contributions for themselves and their families to protect themselves against diseases and to access healthcare services in case of sickness.
[204] Ibid, Article 13.
[205] Ibid, Articles 14 and 16.
[206] Article 11 of the Constitution of the United Republic of Tanzania.
[207] Government of Tanzania, Education and Training Policy.
[208] Ibid. To ensure the protection of the general public from exploitation by private schools, section 57 of the National Education Act bars any private school from charging school fees without the approval of the Commissioner.

schools).[209] The Act has put in place measures to ensure compliance with the established education standards. Section 14 and 15 of the Act prohibit the establishment of private schools without the approval of the Commissioner.[210] Owners and managers of the schools are required to put in place standard infrastructure, equipment and instructional materials necessary to deliver quality education and the school has to be inspected to ensure that it is capable of providing quality education.[211] To ensure the protection of the general public from exploitation, the law bars private schools from charging school fees without the approval of the Commissioner.[212] There have been efforts in recent years to cap the school fees charged by private schools however these efforts have been strongly by private actors on the grounds that they do not reflect the costs they incur in operating schools.[213]

With respect to the health sector, the National Health Policy of 2017 is instructive on the government's position on private healthcare delivery.[214] It envisages a collaboration between faith-Based organizations, the private sector and non-governmental organizations in the provision of health services from the dispensary to the national level. One of the proposed means to implement the Policy is through PPP arrangements.[215] The government also committed to monitor

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[209] Under Section 2 of the Act, "non-government school" means a school wholly owned and maintained by a person, body of persons or any Institution other than the Government. As the same provision, an "owner" can be the Government, local authority, or a person or group of persons owning the buildings of the school. Equally, a "grant in aid" school means a grant of money or education materials and supplies from the Central Government, a local authority or a non-government education authority in aid of any school or group of schools or any educational activity.

[210] See also Section 15 (1) (a), National Education Act as amended. Under Section 59, it is an offence for an owner to operate a school without obtaining approval.

[211] Ibid, Section 15 (1) (a-c). Under Section 28, the Commissioner of Education is empowered to refuse to register a private school on various grounds such as insufficient qualified teaching staff, poor working terms of the staff, unhealthy conditions of the school conditions, the registration of the school being against public interest among others. Section 60 empowers the Minister to make regulations on various aspects to ensure compliance with standards and affordable access to education.

[212] Section 57 of the National Education Act.

[213] BBC, "Tanzania launches school fees crackdown" December 16, 2015 available at https://www.bbc.com/news/world-africa-35111666 (accessed on February 20, 2024). For more recent developments, see The Citizen, "On Private Schools and their cost" November 6, 2018 available at https://www.thecitizen.co.tz/tanzania/magazines/success/on-private-schools-and-their-cost-2660840 (accessed on February 20, 2024).

[214] The United Republic of Tanzania, The National Health Policy 2017, at p.48.

[215] Ibid, p. 49.

and evaluate the role and participation of these non-State actors and adopt appropriate regulations and operational guidelines to ensure delivery of quality health services.[216]

Private Hospitals (Regulation) (Amendment) Act, 1991 was passed to permit the private actors to operate in Tanzania's health sector.[217] Section 6C of the Act entitles any persons and organizations to run private facilities and charge reasonable fees for health services, drugs and equipment. The Act authorizes the Minister to determine, fix and review the 'prices' charged by private hospitals,[218] taking into account various considerations including:[219]

a. The types of medical treatment essential to the community available at private hospitals and at public hospitals;

b. the need to prevent unduly rapid or frequent variation in prices;

c. the need to maintain reasonable standards of services rendered by private hospitals;

d. the need to promote the continued ability of private hospitals to maintain efficiency and expand their services to supplement services rendered by public hospitals; and

e. the need to ensure the availability of adequate medical and health services in rural as well as urban areas; and

f. costs of medical treatment, costs incurred in providing services as well as duties or taxes levied on the facility.

The law further empowers the Minister to issue an order requiring private facilities to display the price structure showing the maximum prices for health services.[220]

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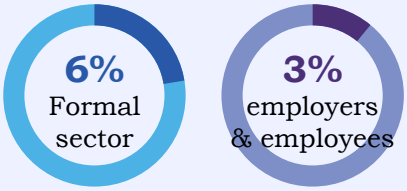
[216] Ibid, p. 44 and 48.
[217] The Private Hospitals (Regulation) Act, 1977 1977 Act initially banned private actors especially the profit ones in the health sector. This Amendment was passed to remove the ban.
[218] Section 17 (1) of the Private Hospitals (Regulation) Act. Section 16 defines the term "price" to mean any fee or other payment of any description charged or chargeable by any private hospital in respect of medical treatment rendered to any person.
[219] Ibid, Section 17 (3) and (4).
[220] Ibid, Section 20.

The Private Hospitals (Standard Guidelines for Health Facilities) Regulations, 1997 lay down the requisite standards to operate a health facility including number of qualified medical workers and minimum standards with respect to equipment, supplies and premises. Private facilities are required to avail their costing mechanisms for various health services to the Ministry of Health on demand. Patients are also entitled to access invoices with full details on the total cost showing each charged component separately. The courts of law have upheld the closure of health facilities for failure to comply with the Regulations. In *Host & Ane Dispensary Associates Company Limited Vs Kinondoni Municipal Council,*[221] the court found that the defendant duly exercised its duty and authority in closing the defendant's business (clinic and dispensary) for failure to comply with the Private Hospitals (Standard Guidelines for Health Facilities) Regulations.

The Medical, Dental and Allied Health Professionals Act, 2017 governs the registration and licensing of health professionals. The Act entitles a person registered as a medical, dental and allied health professional to deliver the respective health services, charge fees and bring claims in courts of law to recover charges for their services.[222]

Tanzania runs a national health insurance system which is governed by several legislations. The Universal Health Insurance Act 2023 makes health insurance mandatory for all citizens in the country as well as foreign residents.[223] It provides for public and private health insurance schemes and includes coverage of employers and employees in the public sector and the private sector; people working in the informal sector; and indigent persons.[224] The public health insurance scheme is the National Health Insurance Fund whereas the private health insurance is largely provided by commercial companies.



The National Health Insurance Fund Act, 2015 governs the National Health Insurance Fund which covers formal sector workers making a monthly 6% contribution (employers and employees contribute 3% each).[225]

[221] Civil Case No. 150 of 2015.
[222] Section 23 (b), Medical, Dental and Allied Health Professionals Act.
[223] Section 5 (1) and (4), Universal Health Insurance Act 2023.
[224] Sections 6, 8 and 9, Universal Health Insurance Act 2023.
[225] Section 4 and 9, National Health Insurance Fund Act.

6

Findings: An assessment of the impact of commercialization of public services on the realisation of human rights

6. Findings: An assessment of the impact of commercialization of public services on the realisation of human rights

This section discusses the impact of commercialization of public services in the East African region using a human rights framework. Specifically, it analyses the extent to which the selected States are meeting their obligations in the context of commercialization through a lens of the essential elements of the right to education and health under the AAAQ framework. It also discusses public debt as a cause and effect of commercialization of public services in the region.

Aspect 1: Impact of commercialization on the realization of the rights to education and health

The AAAQ framework, comprising the elements of availability, accessibility, acceptability, quality (health), is instructive on the obligations of the State to protect, respect and fulfil the rights to education and health.

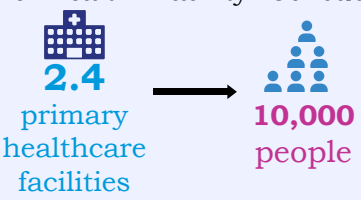
a) Low public investment in public services

Under the availability dimension AAAQ framework, the State is required to ensure that there are facilities of sufficient quantity in place for the enjoyment of the rights to health and education. These include physical infrastructure, education and health professionals as well as the necessary equipment, health supplies and educational materials. Across the region, there is a cross-cutting concern of underfunding of the education and health sectors.

This observation has been made by numerous human rights treaty bodies. For instance, in 2020, the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) noted the rise of low-cost private schools which is coinciding with numerous challenges in Kenya's public education system. These include shortage of teachers, insufficient educational materials in schools and the low number of schools in some parts of the country.[226] The same Committee as well as

[226] Concluding Observations and Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Second Periodic Report of the Republic of Kenya, on the Status of the Implementation of the African Charter on the Rights and Welfare of the Child, 2020 at para 45.

the Committee on the Rights of the Child made similar remarks with respect to Tanzania's health and education spending in 2015[227] and 2017.[228] It observed that there was a misalignment between the health sector budget and demand for health services which affected service delivery especially in rural areas. The Committee also remarked on the low public investment in secondary schools following the removal of tuition costs for secondary education which negatively affected the quality of education.[229] In Kenya, the Health Facility Census Report 2023[230] highlights the low number of health facilities currently standing at a density of 2.4 primary healthcare facilities for every 10,000 people at the national level.[231]



It can be argued that this underinvestment in public services has justified an increase in participation of private actors and consequent relegation of the States' duty to provide to market actors. Tanzanian state officials noted that the country's "formal education systems are unable to accommodate the growing demand" before the Committee on the Rights of the Child in 2015.[232] This sentiment can be deduced from the various health and education polices of these study countries which are urging for private involvement in social service delivery to meet the funding gap by the State. The precariousness of this position is that private for-profit actors are market oriented and as such do not typically set up in rural and marginalized areas which have also been neglected by the governments.

The rise of low-cost private schools, often fronted as an alternative option, has also been influenced by the inadequate quantity of public schools. The Committee on

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[227] Concluding observations on the combined third to fifth periodic reports of the United Republic of Tanzania CRC/C/TZA/CO/3-5, 03 March 2015 at para 54-55. The Committee indicated its concern about the "insufficient allocation of financial resources to child health and, in particular, about: the persistent high maternal mortality and morbidity rates; the limited access to health-care services for children living in poverty and in remote and rural areas."

[228] Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Republic of Tanzania Report on the Status of Implementation of the African Charter on the Rights and Welfare of the Child, 2017 at para 25.

[229] Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Republic of Tanzania Report on the Status of Implementation of the African Charter on the Rights and Welfare of the Child, 2017 at para 25.

[230] Ibid, at para 28.

[231] Ministry of Health, Kenya Health Facility Census Report 2023 at p.56.

[232] Concluding observations on the combined third to fifth periodic reports of the United Republic of Tanzania, 03 March 2015 at para 60.

Economic, Social and Cultural Rights observed this trend in Kenya's education system in 2016 noting that the linkage between underfunding of public schools and 'the proliferation of so-called "low-cost private schools."'[233] These schools are primarily located in urban informal settlements in Kenya where children have limited access to free public schools.[234] Even when located in rural areas, studies have shown that these low-cost schools hardly affordable yet they do not meet minimum standards in some instances. A study by EACH Rights on low fee schools in a rural area in Kenya revealed that majority had an inadequate number of certified teachers, poor infrastructure, poor sanitation facilities, operated without registration and were hardly inspected and regulated by the government.[235] This is not unique to Kenya. Other countries such as Uganda have grappled with this challenge as discussed in the following sub-section.

The threat of private actors supplanting rather than supplementing the government in provision of health and education services is growing. In Kenya, the Basic Education Act No. 14 of 2013 permits the conversion of public schools into private schools yet it is silent, or does not envisage a reverse arrangement.[236] On the health front, recent studies have shown that amidst declining public funding for health services, the Kenyan government spends significant resources in "contracting private facilities to provide healthcare services."[237] For instance, from 2011 to 2021, the NHIF has consistently spent considerably more on private health facilities than those of the government providers in addition to refunding the former at higher rates.[238]

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[233] Committee on Economic, Social and Cultural Rights, Concluding observations on the combined second to fifth periodic reports of Kenya, 2016, E/C.12/KEN/CO/2-5, Para 57-58

[234] EACH Rights, "Low cost private schools: School choice for the poor at the expense of quality?" (2017) available at https://www.right-to-education.org/sites/right-to-education.org/files/resource-attachments/EACHRights_Low_Cost_Private_Schools_2017.pdf (accessed on March 10, 2024). See also, Ngware Moses, "The irony of poor urban children left out from free schooling" African Population and Health Research Center (2018) available at https://aphrc.org/blogarticle/the-irony-of-poor-urban-children-left-out-from-free-schooling-june/ (accessed on March 10, 2024).

[235] EACH Rights, ibid.

[236] Section 43 (2). This risk is discussed in the Abidjan Principles on the Right to Education at para 48.

[237] The Economic and Social Rights Centre – Hakijamii and the Center for Human Rights and Global Justice, "Wrong prescription: The impact of privatizing healthcare in Kenya" (2021) at p. 19-20.

[238] Ibid. In particular, see the response by Kenya's NHIF at p. 4-5 available at https://chrgj.org/wp-content/uploads/2022/03/NHIF-response-to-CHRGJ-query.pdf (accessed on March 31, 2024).

b) Accessibility of health and education services

This element of the right to health and education entails removal of barriers which hinder access to these public services. The Special Rapporteur on extreme poverty and human rights has indicated that commercialization "often involves the systematic elimination of human rights protections and further marginalization of the interests of low-income earners and those living in poverty." Costs for public services is an example of a major barrier which can result in the exclusion of especially for the poor and vulnerable groups.[239]

With regard to economic accessibility, commercialization not only on increases horizontal inequality (between groups based on grounds such as gender, disability, age, health status) but also exacerbates vertical inequality (among individuals and households based on disparities in income or wealth).[240] High costs of healthcare and education are fueling economic inequality and deepening the divide between the wealthy and the poor, rather than bridging the gap, in accessing public services. For instance, while all the countries provide free primary level education, the hidden costs inhibit access for children from low income households who are unable to afford the services.

In Uganda, close to three decades since the introduction of UPE in 1997, theb capitation grant at primary level remained between UGX 5,000/= and UGX 18,000/= annually.[241]

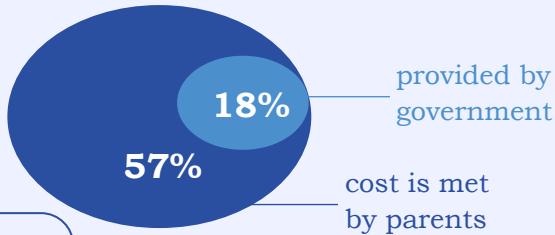
Since 1997 UPE capitation grant annually is between **UGX 5,000/= & UGX 18,000/=**

This falls short of the (also low) recommendation by the National Planning Authority (NPA) of a minimum annual expenditure of UGX 59,503 per learner.[242]

UGX 59,503 per Learner recommendation by the National Planning Authority (NPA)

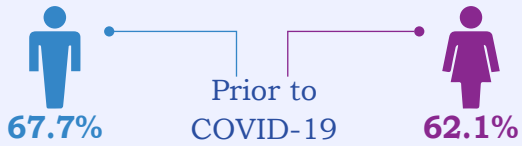
[239] United Nations General Assembly, 'Report of the Special Rapporteur on extreme poverty, Philip Alston' A/73/396 at para 48.
[240] Rosella De Falco et al, "Assessing the Human Rights Framework on Private Health Care Actors and Economic Inequality" Health and Human Rights Journal 25 (2), (2023).
[241] The National Planning Authority (NPA), "Issues Paper on Uganda's Education Reforms Submitted to: Education Policy Review Commission" (2022) at p. 31.
[242] Ibid.

As of 2018, the government provided only 18% of the required public financing for education while parents met 57% of the cost.[243]



At the secondary level capitation grant of approximately **UGX 51,000/=** far below the recommended minimum public expenditure of **UGX 177,500** ($45) per term.[244]

Prior to the outbreak of the COVID19 pandemic, the Uganda Bureau of Statistics estimated that 67.7% of boys and 62.1% of girls drop out of school due to high costs of education.[245] In the aftermath of the COVID-19 lockdown, NPA estimated that **64.6%** of parents were either struggling or not in position to afford tuition and non–tuition fees for their children.[246]



drop out of school due to high costs of education

Similar trends have been observed in other countries.[247] The Committee on the Rights of the Child noted that the right to a free compulsory education was being infringed by hidden costs in Kenya and urged the State to prioritize public education over provision by private actors.[248] Despite laws and policy in place guaranteeing free education, some public schools still require parents to make

[243] Ibid.
[244] Ibid.
[245] Uganda Bureau of Statistics (UBOS), 2021. Uganda National Household Survey 2019/2020. Kampala, Uganda; UBOS, p. 29.
[246] National Planning Authority (2021), Towards Safe Opening of The Education Sector in Covid-19 Times: Technical Note, Kampala at p. 12.
[247] The Committee on the Rights of the Child Concluding observations on the combined third to fifth periodic reports of Kenya, 2016, CRC/C/KEN/CO/3-5
[248] Committee on the Rights of the Child, 'Concluding observations on the combined third to fifth periodic reports of Kenya', 2016, CRC/C/KEN/CO/3-5 at para 57 and 58.

financial contributions towards other non-tuition costs.[249] However, these costs remain unregulated, which has raised the cost of education and undermines the intention and purpose of free education.[250] In Rwanda, data on the period immediately preceding the COVID-19 pandemic revealed a rise in school dropouts attributed in part to the hidden costs of education such as non-tuition costs.[251] In 2020, the Committee on the Rights of the Child expressed concern about this issue.[252] Studies on Rwanda's free education have revealed that "it is children from better-off homes that continue to benefit disproportionately from the introduction of fee-free education" compared to their counterparts from low income households.[253] High costs are deepening vertical inequality in the region as aptly explained by Uganda's NPA:

> to compensate for the below threshold [government] funding, parents disproportionately make higher contributions for their children to enroll and remain in school. This affects enrolment by limiting it to the slightly wealthy families.[254]

[249] These include learning materials, food, medical expenses among others. See, Richard Shukia, 'Fee-free Basic Education Policy Implementation in Tanzania: A Phenomenon Worth Rethinking' (2020) Huria Journal Vol. 27 (1).

[250] Amy Curren, "The hidden costs of 'free' schools in Tanzania' (2021) EdUKaid available at https://www.edukaid.com/blog/the-hidden-costs-of-free-schools-in-tanzania-#:~:text=In%20December%202015%2C%20the%20Tanzanian,increase%20in%20primary%20school%20enrolment (accessed on December 11, 2023).

[251] United Nations Children Fund (UNICEF), Education Budget Brief, Investing in Child Education in Rwanda FY 2022/23, P.5, supra. At the primary level, the overall dropout rate increased to 9.5% in 2019/20 from 7.8% in 2018/19 whereas in secondary, the school dropout increased from 4.4% in 2016/17 to 10.4% in 2019/20.
See also, Laterite, 'Factors and drivers of dropout and repetition in Rwandan schools: Towards evidence-based policies to improve the quality of education,' (2019) Policy Brief.

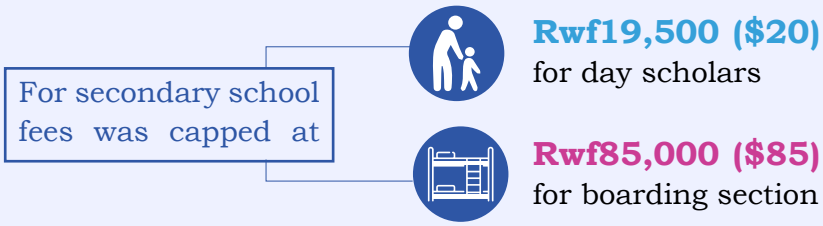
[252] United Nations Committee on the Rights of the Child, Concluding observations on the combined fifth and sixth periodic reports of Rwanda CRC/C/RWA/CO/5-6, 28 February 2020 at para 38.

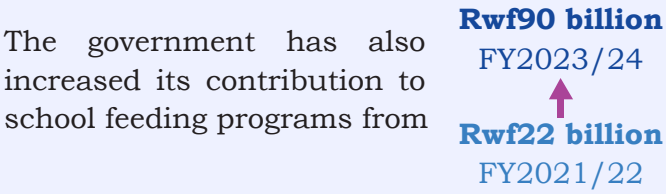
[253] Timothy P. Williams, et al., 'Education at our school is not free': the hidden costs of fee-free schooling in Rwanda, (2015) Compare: A Journal of Comparative and International Education, at p.17

[254] Ibid. at p.29.

Regulation of school fees

Some countries in the region are attempting to address this financial barrier to access to education by regulating tuition and non-tuition costs levied by public and government aided or subsidized schools. In the academic year 2022-2023, the Rwandan Ministry of Education harmonized its tuition structure and implemented fee caps for public and government-subsidized primary and secondary schools.[255] At pre-primary and primary levels, parents are not required to pay costs except a contribution of **Rwf975** for the school feeding program.[256] For secondary education, the fees were capped at Rwf19,500 ($20) for day scholars and Rwf85,000 ($85) for learners in the boarding section.[257] The government has also increased its contribution to school feeding programs from Rwf22 billion in FY2021/22 to Rwf90 billion n F2023/24 to take into account inflation and high cost of essential food items.[258]





[255] Alice Kagina, 'Gov't scraps tuition fees for public primary schools' The New Times, September 15, 2022 at https://www.newtimes.co.rw/article/1067/news/rwanda/govt-scraps-tuition-fees-for-public-primary-schools (accessed on March 15, 2024).
[256] Ibid.
[257] Ibid.
[258] Aurore Teta Ufitiwabo, 'Rwanda: School feeding programme budget rises to Rwf 90 bilion: what it means' The New Times, February 15, 2024 at https://allafrica.com/stories/202402170213.html#:~:text=The%20programme%27s%20budget%20rose %20from,the%202023%2F2024%20fiscal%20year. (accessed on March 15, 2024).

Box 2

Regulation of School Fees in Uganda

Over the years, the Ministry of Education and Sports has made several attempts by issuing guidelines and circulars to local governments and heads of primary and secondary schools.[259] For instance, in 2017, the Permanent Secretary of the Ministry of Education and Sports issued guidelines on school charges.[260] The guidelines were to the effect that no school would be allowed to make any school fee adjustments without approval by the ministry. These guidelines strictly prohibited non-cash requirements outside the approved school fees and refrained Government-aided schools from taking commercial loans except with authorization from the Minister of Finance Planning and Economic Development.

The above efforts have not yielded much effort and have always been ignored by schools – public, government-aided aided and private schools alike.[261] This can be largely attributed to the fact that these issued guidelines do not have the force of law and lack teeth in instances of non-compliance. Sections 3 and 57 of the Education Act, 2008 empower the Minister responsible for education to issue statutory instruments to regulate various aspects of the education sector including the fee structure for all schools. However, since the enactment of the Act, this has not been done. This duty of the Minister has been subject to litigation in courts of law.[262]

This is demonstrative of a lack of political will by the current government to regulate fees in schools and is in sharp contrast with the approach taken by previous governments. For instance, in the 1980s, school fees in both primary and secondary schools were regulated through statutory instruments which

[259] Ministry of Education and Sports, Guidelines for Reopening of Education Institutions and Implementation of COVID19 Standard Operating Procedures (SOPs) (2021) at p.7.
[260] Business Focus "Education Ministry Issues Strict Guidelines on School Fees" November 23, 2017 available at https://businessfocus.co.ug/education-ministry-issues-strict-guidelines-school-fees/ (accessed on January 28, 2024).
[261] See for instance, the Observer "Schools defy Janet on fees," September 7, 2022 at https://observer.ug/news/headlines/75031-schools-defyjanet-on-fees (accessed on January 28, 2024).
[262] Michael Aboneka and Ors v Attorney General, Misc. Cause No. 15 of 2022.

detailed the fees to be charged in both boarding and day schools.[263] The latest development is the issuance of a cabinet directive restricting all schools from charging certain charges as part of their school fees structure including scholarships/bursaries, purchase of property, salaries of employees, legal fees, loans and charges to facilitate the various governing bodies.[264]

The discussion on regulation of school fees is typically limited to public and subsidized schools. The right of parents to freely choose an education institution does not give a free pass to private actors to charge school fees which are exploitative. The State has an obligation to protect parents who opt to enroll their children in private schools from financial exploitation. All the study countries permit private schools to develop their own fees structure. However, Rwandan and Tanzanian education laws require private schools to obtain the approval of government officials on the school fees chargeable.[265] Currently, none of the countries have a harmonized school fees structure for private schools. Tanzania attempted to regulate fees charged by private actors in 2015 however, these efforts have been strongly resisted by private actors.[266]

The current context on access to education in the region depicts the fears of socio-economic segregation raised by the CESR.[267] Good quality education is increasingly becoming "a privilege affordable only to the wealthiest segments of society" while children from low income households are forced to attend underfunded public schools or low cost private schools which may not meet minimum standards.

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[263] See; The Education (Primary School Fees) Regulations, SI 127—5; and The Education (Post primary Institutions School Fees) Regulations, SI 127—6 that were issued by the Obote II Administration.

[264] Daily Monitor, "Government to close schools over high fees' (2024) available at https://www.monitor.co.ug/uganda/news/national/govt-to-close-schools-over-high-fees--4538742 (accessed on February 29, 2024).

[265] Section 57 of the National Education Act (Tanzania) and Article 41 of the Law N°23/2012 of 15/06/2012 Governing the Organization and Functioning of Nursery, Primary and Secondary Education (Rwanda).

[266] BBC, "Tanzania launches school fee crackdown' December 16, 2015 available at https://www.bbc.com/news/world-africa-35111666 (accessed on March 15, 2024).
For more recent developments, see The Citizen, "On Private Schools and their cost" November 6, 2018 available at https://www.thecitizen.co.tz/tanzania/magazines/success/on-private-schools-and-their-cost-2660840 (accessed on February 20, 2024).

[267] Committee on Economic, Social and Cultural Rights General Comment No. 24 (2017) on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities at para 22.

Regulation of private healthcare costs

As with the education sector, commercialization is deepening inequalities in access to healthcare in the region. On private health provision, the CESR in its General Comment No. 14 indicated that the government obligation to ensure the availability, accessibility, acceptability of quality health services, facilities and supplies should not be compromised by commercialization.[268] The Committee elaborated further in General Comment 24 that private health-care actors should be strictly regulated and "prohibited from denying access to affordable and adequate services, treatments or information."[269] According to 2021 data from the World Health Organisation (WHO) populations of all the study countries still pay a high percentage of the health expenditure out-of-pocket (Figure 2). Uganda (31%), Kenya (23%), Tanzania (26%) and Rwanda (10%) (Figure 2). The burden of high health costs is usually felt disproportionately by low income and poor households.

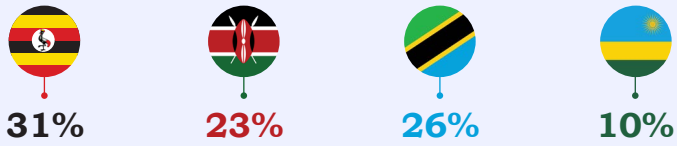
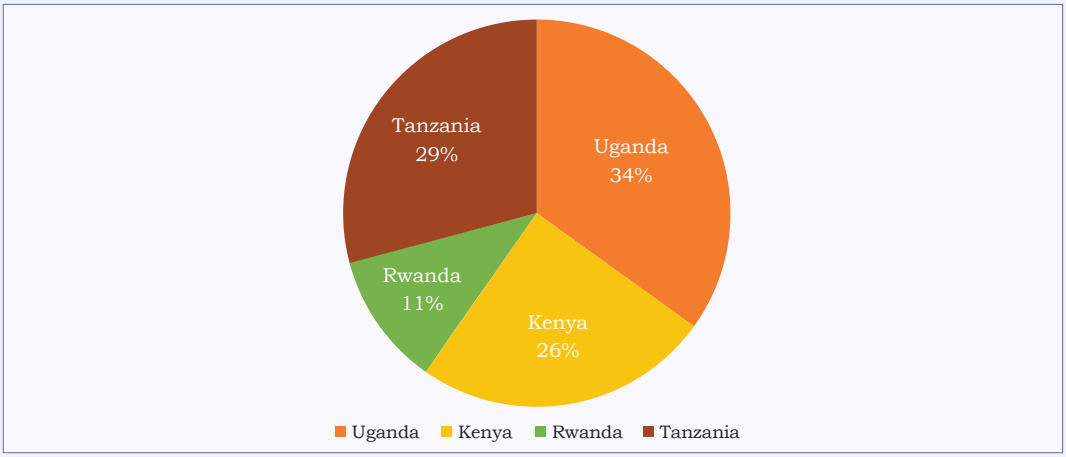


Figure 1: Out of pocket health expenditure



Source: World Health Organisation (WHO)[270]

[268] General Comment No. 24, at para 21.
[269] Ibid.
[270] World Health Organisation (WHO), Global Health Observatory data repository available at https://apps.who.int/gho/data/view.main.GHEDOOPSCHESHA2011v (accessed on March 1, 2024).

The persistent underfunding of the health sector is cause for concern. For instance, the CESR noted that the inadequate budgetary allocation for health and low coverage of health insurance in Kenya resulted in the exclusion of the poor.[271] Similarly, studies have shown that Rwanda's Community Based Health Insurance (CBHI) scheme, through which the informal sector is covered, is unaffordable for poor households.[272] Despite being commended for lowering out of pocket expenses,[273] an IMF study revealed that the scheme benefits the country's better off households who are more likely to enrol than the poor.[274] Uganda has the highest out of pocket expenses and is the only country which does not have a health insurance scheme in place. Long term investment in the public health system has been chronically affected by the budget cuts over the years.[275] The impact is felt the most by the poor, vulnerable groups and persons living in marginalized areas, who heavily rely on public health facilities.[276]

Across the region, only Kenya has set guidelines on the costs chargeable by health professionals.[277] The Cabinet Secretary issued the Medical Practitioners and Dentists (Professional Fees) Rules, 2016 set the minimum and maximum professional costs chargeable for medical and dental procedures.[278] Under Tanzanian law, the Minister of Health has the power to determine, fix and

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[271] Committee on Economic, Social and Cultural Rights, Concluding observations on the combined second to fifth periodic reports of Kenya, 2016, E/C.12/KEN/CO/2-5, Para 51-52.

[272] IMF, 'The Impact of Community Based Health Insurance Schemes on Out-of-Pocket Healthcare Spending: Evidence from Rwanda', 2019 at p. 4.

[273] Concluding observations and recommendations on the combined 11th, 12th and 13th periodic report of the Republic of Rwanda under the African Charter on Human and Peoples' Rights and Initial Report under the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2019 at para 76.

[274] Ibid. at p.15.

[275] initiative for Social and Economic Rights (ISER), "Are we failing to progressively realize the right to health in Uganda? An analysis of health sector budget trends" (2018) at https://iser-uganda.org/wp-content/uploads/2022/07/health_budget.pdf (accessed on March 20, 2024).

[276] Uganda Bureau of Statistics (UBOS), National Service Delivery Survey, 2021 at p. 87. "At the national level, 45 percent of the household members reported that they first sought consultation from government health centres/hospitals, followed by 37 percent that sought consultation from private hospital/clinic/nurse/doctor. Rural residents were more likely to seek first treatment from government hospital/health centre whereas urban residents were more likely to seek from the private clinic/hospital.

[277] Section 23 of the Medical Practitioners and Dentists Act cap 253, empowers the cabinet secretary in consultation with the council to issue various rules to guide the implementation of the Act. The Cabinet Secretary issued the Medical Practitioners and Dentists (Professional Fees) Rules, 2016 which set out the minimum and maximum professional costs chargeable by medical and dental practitioners for various medical and dental procedures.

[278] Regulation 3 of the Medical Practitioners and Dentists (Professional Fees) Rules, 2016.

review the 'prices' charged by private facilities and order for the display the price structure to the public.[279] Recent efforts by the Tanzanian government to regulate the fees charged by private facilities were foiled. The government's proposal to implement new (lower) rates for the National Health Insurance Fund (NHIF) this year was shelved following resistance from private service providers.[280]

In Uganda, the issue of high charges levied by private health facilities has been a subject of litigation before courts of law.[281] Particularly, during the COVID-19 pandemic, there was public outcry and numerous calls to the government to regulate the costs of private healthcare. It remains to be seen whether the Ministry of Health will observe the order of court to adopt a law regulating and standardizing rates and charges levied by private health facilities.

Closely related to the high costs of healthcare is the unethical practice of detention of patients for unpaid medical bills at health private facilities. Previous ISER research showed that this practice, which is widespread in Uganda, violates the right to liberty, health and dignity.[282] It has also been declared unconstitutional by Ugandan courts of law.[283] Similarly, studies have revealed that this practice is also common in Kenya highlighting a case of where over 60 women were detained in a hospital for failing to pay their medical bills.[284] Kenyan legislators have picked interest and proposed a law, the Health (Amendment) Bill 2023, outlawing the detention of patients and corpses in hospitals and mortuaries due to

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[279] Section 17 and 20 of the Private Hospitals (Regulation) Act. Section 16 defines the term "price" to mean any fee or other payment of any description charged or chargeable by any private hospital in respect of medical treatment rendered to any person.

[280] The East African, Tanzania makes U-turn on reduced NHIF rates after private sector protests, January 5, 2024 at https://www.theeastafrican.co.ke/tea/business/tanzania-u-turn-reduced-nhif-rates-private-sector-protests-4483014 (accessed on February 15, 2024). The Association of Private Health Facilities in Tanzania (APHFTA) argued that the revised fees would cause huge losses, citing the high costs of running their facilities.

[281] See Health Equity and Policy Initiative v Hon Jane Ruth Acheng Ocero, Minister of Health and Anor High Court Miscellaneous Cause No. 210 of 2018 (2024). The court ordered the ministry of Health to adopt legislation regulating and standardizing rates and charges levied by private health facilities.

[282] ISER, 'When patient becomes prisoner: Detention in Health Facilities in Uganda' (2021) at https://iser-uganda.org/wp-content/uploads/2022/07/When_Patient_Becomes_Prisoner.pdf (accessed on March 15, 2024).

[283] Center for Health, Human Rights, and Development (CEHURD) and Ors v Jaro Hospital Limited & Anor (Uganda).

[284] Robert Yates at al, 'Hospital detentions for non-payment of fees: A denial of rights and dignity' Centre on Global Health Security (2017).

unpaid bills.[285] In Rwanda, media outlets reported that the practice happens at health facilities in Kigali.[286] The government refuted the claims, asserting that detaining patients was an unlawful.[287] Currently, there are no policies or guidelines issued by any of the governments in the region on this issue.

c) Acceptability and quality of services

In the context of commercialization, the State has an obligation to protect its population from violation of its rights by private actors. As stated by the African Commission on Human and Peoples Rights, "whenever a public actor participates in social service provision, they perform a core public function that demands a high level of protection of the collective interest." The legal framework of all the study countries require private actors who intend to found and operate schools to comply with the established education standards. In some instances, failure to meet standards has prompted the closure of schools by government officials. The example of Bridge International Academies (BIA) operating in Uganda and Kenya stands out. These schools received wide support including funding from international financial institutions such as the International Finance Corporation, as well as bilateral donors such as the UK. The IFC divested from the company after close to a decade and is currently on the spot for continuing its funding amidst allegations of sex abuse at the schools.[288]

BIA has been subjected to litigation in both Kenya and Uganda for failing to comply with educational standards including registering their operations (Annex).[289]

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[285] Mwangi Muiriri, "Leaders back push to outlaw detention of patients, bodies in hospital" Nation, June 5, 2023 at https://nation.africa/kenya/news/leaders-back-push-to-outlaw-detention-of-patients-bodies-in-hospitals-4258318 (accessed on March 15, 2024).

[286] The Chronicles, "Inside Kigali's hospitals "detaining" patients unable to pay treatment bills" August 26, 2019 at https://www.chronicles.rw/2019/08/26/inside-kigalis-hospitals-detaining-patients-unable-to-pay-treatment-bills/ (accessed on March 15, 2024).

[287] The Chronicles, "Health Ministry: There is no single patient detained in Kigali hospitals" August 28, 2019 at https://www.chronicles.rw/2019/08/28/health-ministry-there-is-no-single-patient-detained-in-kigali-hospitals/ (accessed on March 15, 2024).

[288] Caroline Kimeu, "World Bank accused of 'turning a blind eye' to sexual abuse in Kenyan schools it funded' The Guardian, December 4, 2023 at https://www.theguardian.com/global-development/2023/dec/04/world-bank-accused-of-turning-blind-eye-to-sexual-abuse-in-kenyan-schools-it-funded (accessed on March 18, 2024).

[289] Bridge International Academies (K) Ltd v Attorney General (Uganda) (Miscellaneous) Application No. 2511 of 2016) [2017] and Republic v The County Education Board & Ors (Kenya) Judicial Review No. 3 of 2016.

The Courts agreed with the decision of regulators to close the schools on the grounds that they were not meeting the basic minimum standards prescribed by law. These include registration with the Ministry of Education, good sanitary conditions and hiring of qualified teaching staff.[290] These cases demonstrated that the common public perception that services provided by private actors are of a superior quality is not always accurate.[291] While BIA schools stand out as an illustration of regulators exercising their powers to hold private actors accountable, there are instances where private actors have continued to operate in the shadow of the law. This poses a risk of exposing the public to substandard services and widening inequalities since it is the poor who are likely to fall to prey.

With regards to health service delivery, Uganda committed, in its first National Health Policy, to "constantly monitor and periodically evaluate the effect of privatization in the health sector" this has not been done.[292] In comparison, Tanzania and Rwanda have a more elaborate regulatory framework on private healthcare which lays down the minimum standards with respect to health workers, equipment, supplies and premises.[293]

While all the study countries have laws and policies requiring registration as well as regulation and monitoring of private actors in place, none provide for obligations of private actors to deliver social services as a public function. The African Commission on Human Rights and Peoples Rights expounded on the 'public service obligations' of private actors including provision of quality services on a basis of non-discrimination, ensuring accessibility, and democratic public accountability.[294]

[290] Ibid.
[291] ISER and Global Initiative for Social and Economic Rights (G-ISER), "Privatisation, discrimination and the right to education in Uganda: Alternative Report" (2015) at p.16.
[292] Uganda National Health Policy at para 9.2 (f).
[293] See Rwanda Private Health Facility Licensing Standards, 2017 and Tanzania Private Hospitals (Standard Guidelines for Health Facilities) Regulations, 1997. Tanzanian courts of law have upheld the closure of health facilities for failure to comply with the Regulations.
[294] The African Commission on Human Rights and Peoples Rights General Comment No. 7, para 15.

Aspect 2: High public debt as a driver of commercialization of public services

By the 1990's, all four study countries shouldered heavy debt burdens and eventually Uganda, Rwanda and Tanzania benefited from the IMF and World Bank Heavily Indebted Poor Countries (HIPC) debt relief programme in the 1990's.[295] Aside from the critique that the programme did not achieve its goal of long term sustainability for beneficiary States,[296] these countries were also required to undertake reforms including promotion of private sector involvement and participation in delivery of public services, a driver of the ongoing commercialization.[297]

African countries continue to face debt challenges to date in part because of the global debt architecture which does not readily offer support to countries grappling with unsustainable debt. The COVID-19 pandemic exposed this dilemma as several African countries struggled to support their population amidst a health crisis and economic downturn while continuing to make debt repayments, particularly to multilateral and private creditors (Figure 1 and Figure 2).

Over the past decade, external debt repayments have risen significantly - almost tenfold for Rwanda,[298] and beyond this mark for both Uganda and Tanzania (Figure 1). The impact of this is demonstrated by the surge in the government revenues spent on external debt repayments in all the four countries during the

[295] World Bank, Heavily Indebted Poor Countries (HIPC) Initiative available at https://www.worldbank.org/en/topic/debt/brief/hipc (accessed on March 20, 2024).

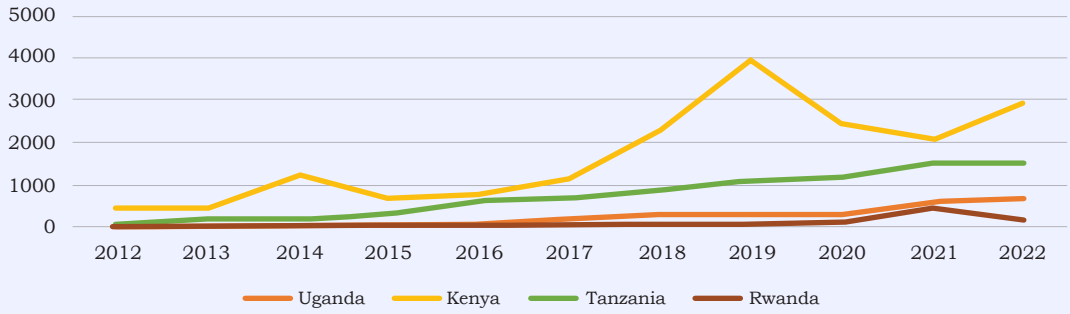
[296] See also, UNCTAD, "Economic Development in Africa: Debt Sustainability: Oasis or Mirage?" (2004), United Nations. See also, Cephas Lumina and Nona Tamale, 'Sovereign Debt and Human Rights: A focus on Sub-Saharan Africa" (2021) Afronomicslaw.

[297] For Rwanda, see International Development Association (IDA) and IMF, "Rwanda: Decision Point Document for the Enhanced Initiative for Heavily Indebted Poor Countries (HIPC)" (2000) IDA and IMF at p. 20.
For Uganda, see International Development Association (IDA) and IMF, "Uganda: Decision Point Document for the Enhanced Initiative for Heavily Indebted Poor Countries (HIPC)" (2000), IDA and IMF at p. 26.
For Tanzania, see International Development Association (IDA) and IMF, "Tanzania: Decision Point Document for the Enhanced Initiative for Heavily Indebted Poor Countries (HIPC)" (2000), IDA and IMF at p. 22.

[298] World Bank International Debt Statistics – Rwanda available at https://datatopics.worldbank.org/debt/ids/countryanalytical/rwa/counterpartarea/wld# (accessed on March 20, 2024).

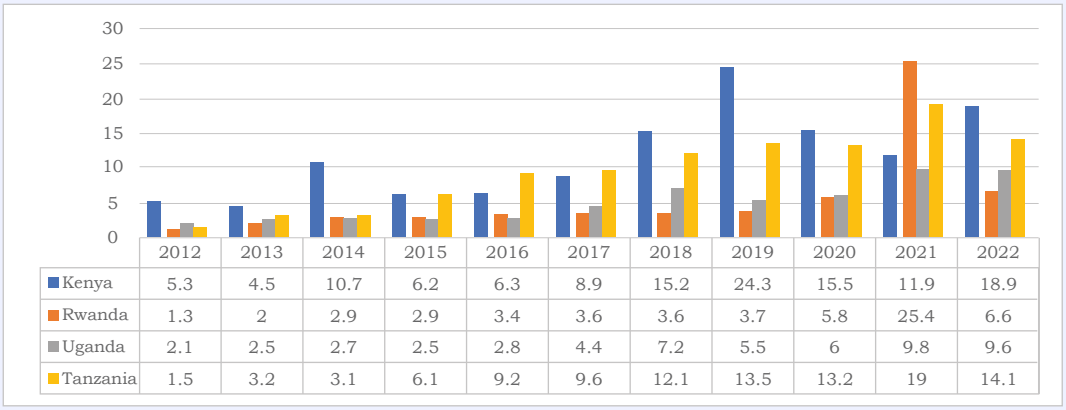
same period (Figure 2) amidst an ongoing trend of declining revenues in Africa.[299] This has significantly reduced the available financial resources for public services in the region. For instance, in 2021, all the study countries spent more than 10% of their revenues on external debt repayments (Figure 2).

Figure 2: External debt repayments (principal and interest) over the past decade ($ millions)



Source: World Bank International Debt Statistics[300]

Figure 3: External debt repayments as a percentage of government revenue (2012-2023) (%)



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Kenya	5.3	4.5	10.7	6.2	6.3	8.9	15.2	24.3	15.5	11.9	18.9
Rwanda	1.3	2	2.9	2.9	3.4	3.6	3.6	3.7	5.8	25.4	6.6
Uganda	2.1	2.5	2.7	2.5	2.8	4.4	7.2	5.5	6	9.8	9.6
Tanzania	1.5	3.2	3.1	6.1	9.2	9.6	12.1	13.5	13.2	19	14.1

Source: World Bank International Debt Statistics[300]

[299] African Development Bank Group, "Summary for Policymakers, Domestic Revenue Mobilization in Africa During Crisis and Beyond" (2022) at p.8.

[300] World Bank, International Debt Statistics website available at https://www.worldbank.org/en/programs/debt-statistics/ids (accessed on March 30, 2024).

[301] Debt Justice, Debt Data Portal website available at https://data.debtjustice.org.uk/ (accessed March 30, 2024).

Currently, Kenya is at high risk of external debt distress[302] and yet it has continued to borrow from international capital markets at high interest rates.[303] While the other three countries are considered to be at moderate rate of debt distress,[304] this is dubitable from a human rights perspective. There is a dissociation between the current criteria for measuring debt sustainability and the human rights implications of heavy debt burdens. The current assessments of debt sustainability focus more on ensuring repayment of debt to creditors in the short term than on the required long-term investment in human rights.[305] This creates a misleading picture of financial health which encourages more borrowing even while countries struggle to meet their human rights obligations and sustainable development goals.[306] For instance, the ratio of interest payments to health expenditure of the study countries increased over the years (Figure 4). A rise is noted particularly between 2019 and 2021 when the COVID-19 pandemic associated effects were felt the most, with Uganda spending over 4% of its health expenditure on interest payments (Figure 4). In addition, the predominant IMF policy prescription of fiscal consolidation or austerity to countries burdened by debt, in order to meet debt repayments to creditors, further impacts government expenditure on public services.[307]

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[302] IMF, "List of LIC DSAs for PRGT-Eligible Countries" available at https://www.imf.org/external/pubs/ft/dsa/dsalist.pdf (accessed March 20, 2024).

[303] African Sovereign Debt Justice Network, "Kenya successfully issues a new $1.5 billion Eurobond to buy back the $2 billion Eurobond due June 2024" Afronomicslaw available at https://www.afronomicslaw.org/print/pdf/node/2803 (accessed on March 20, 2024).

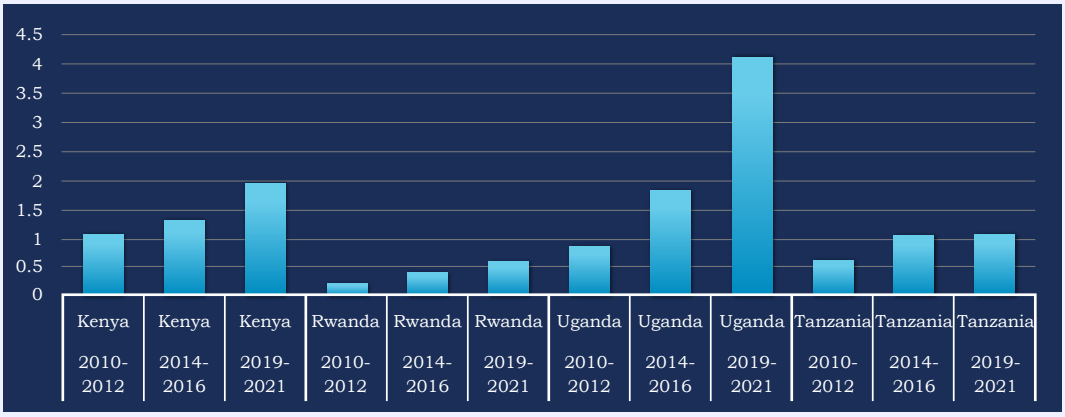
[304] IMF, "List of LIC DSAs for PRGT-Eligible Countries", supra.

[305] Nona Tamale, "Debt Restructuring under the G20 Common Framework: Austerity Again? The case of Zambia and Chad" in James Gathii, "How to Reform the Global Debt and Financial Architecture" (2023) Sheria Publishing House.
See also, UNCTAD, "Financing for Development: Debt and debt sustainability and interrelated systemic issues" (2018) at p.11.
See also,

[306] For more information on Uganda, see ISER, "Uganda's rising debt and public services: A human rights impact assessment" (2022).

[307] Nona Tamale, "Adding fuel to fire: How IMF demands for austerity will drive up inequality world-wide" (2021) Oxfam International.
See also, Nona Tamale, "Debt Restructuring under the G20 Common Framework: Austerity Again? The case of Zambia and Chad" supra.

Figure 4: Ratio of public interest payments to health expenditure



Source: UN Trade and Development World of Debt Report 2023[308]

The rise of domestic debt in the region is also a budding cause for concern. While there are less currency risks compared to borrowing on international financial markets, this type of debt is growing as a proportion of public debt as African countries increasingly turn to their domestic markets to fill financing shortfalls. However, it is not without challenges. Domestic debt is typically issued with short maturity periods thus increasing exposure to "roll over risks, where governments continually borrow to settle maturing obligations."[309] This borrowing trend is likely to perpetuate the ongoing debt cycle in the region and further cripple investment in public services as countries channel financial resources to debt repayments. For instance, in 2022, Kenya (4% of GDP) and Uganda (2.5% of GDP) spent more on domestic debt repayments than on their education expenditure.[310]

[308] UN Trade and Development, "World of Debt" (2023) available at https://unctad.org/publication/world-of-debt (accessed on March 31, 2024).
[309] United Nations Department of Economic and Social Affairs (DESA), 'Debt sustainability challenges in Africa: The role of domestic debt" (2024) Monthly briefing No. 180 at p. 3.
[310] Ibid. at p.4.

Aspect 3: Public debt as an effect of commercialization of public services

The growing reliance on the private sector to finance SDGs has seen a rise in the promotion and use of financial instruments, some of which are debt creating, to finance public services globally. One notable instrument is public private partnerships (PPPs). The African Commission on Human Rights and Peoples Rights in General Comment No. 7 described PPPs in the context of commercialization as follows:

> A common mechanism for diverting public resources to private actors for the provision of social services are public-private partnerships (PPPs). PPPs vary, but often take the form of long term contractual arrangements between states and private actors, which see the private sector assuming a significant role in the provision of social service infrastructure, or the services themselves in return for payments in the form of user fees, government funding, or other support.[311]

Typically, the domestic laws on PPPs and the contracts indicate how risks are distributed "between the public and private sector, while the State's derisking commitments are recorded as contingent liabilities, and do not count as public debt."[312]

[311] African Commission on Human Rights and Peoples Rights General Comment No. 7, para 54-56.
[312] Daniela Gabor, "The Wall Street Consensus" (2021), Volume 52, Issue 3, Development and Change, International Institute of social Studies.

Box 3

Legal, policy and institutional framework governing the delivery of social services through public private partnerships (PPPs)

Uganda

Public-Private Partnership Framework Policy, 2010
This policy was adopted to facilitate PPP arrangements in the provision of public services and public infrastructure. Its aims include: better utilization and allocation of public funds; more efficient development and delivery of public infrastructure; ensure good quality public services; and boosting economic growth and foreign direct investments.

Public Private Partnership Act, 2015
It is the primary legislation which governs the development and implementation of PPPs in Uganda. It also establishes the key institutions tasked with the implementation of the PPPs. PPPs may be entered for social infrastructure projects including health and education facilities.[313]

Risk assumption: The Act requires private parties to assume the risks (financial, technical and operational) in the PPP arrangement.[314]

Financing of PPPs: The Act permits government bodies to finance PPPs through monetary contributions, concessions on the use of government assets or assignment of rights to operate and exploit assets.[315] The government is prohibited from borrowing to finance PPPs except in accordance with the Constitution.[316]

[313] Section 2 (1), PPP Act.
[314] Sections 2 (definition of a PPP) and Section 3 (a), ibid.
[315] Section 12 (2), ibid.
[316] Section 12 (3), ibid.

The Public Private Partnerships Regulations, SI No. 18 of 2019 and the National Public-Private Partnerships Guidelines

The Regulations provides for the management of PPPs, procedures for project inception and feasibility study, bidding methods, negotiation procedures, direct procurement as well as the levies and tariffs that the Contracting Authority may levy.

The Guidelines outline the procedural framework and set of assessment tools for contracting authorities and the PPP Unit on project identification and implementation.

PPP Committee

It directly oversees and approves all projects developed under the PPP model.

PPP Unit

It serves as the secretariat and technical arm of the PPP Committee.

The Education (Pre-Primary, Primary and Post-Primary) Act, 2008

The Act aim to promote partnership amongst various stakeholders providing education services.[317] It underpinned the PPP scheme in the implementation of the Universal Secondary Education Program that was later phased out in 2018.

National Policy on Public-Private Partnership in Health

The Ugandan government has committed to partner with the private sector in the following areas: policy development, health sector strategic plan monitoring and evaluation, co-ordination and planning, financial resource mobilization and allocation, human resource for health management, community empowerment and involvement, service delivery. The policy bolsters the government partnership with the not–for–profit health facilities through which they receive primary health care grants.

[317] Section 1 (e), The Education (Pre-Primary, Primary and Post-Primary) Act, 2008.

Kenya

Policy Statement on Public Private Partnership 2011

The Policy articulates the Kenyan government's commitment to the public and private partnerships agenda and provided a basis for the enactment of the country's PPP Law to strengthen the existing legal and regulatory framework. It laid a foundation for the establishment of institutions to champion the PPP agenda, mobilization of domestic and international private sector investments, and Government support for PPP projects.

The Public-Private Partnerships Act, No. 14 of 2021

The objectives of the Act include: prescribing the procedures for the participation of the private sector in the financing, construction, development, operation or maintenance of infrastructure or development projects through public-private partnerships.[318] The Act governs the financing, design, construction, rehabilitation, operation, equipping/ maintenance of all projects or provision of a public services undertaken under the PPP model.[319]

Risk allocation: Under the Act, the private party is liable for the risks arising from the projects.[320]

Financing of the PPP arrangement/projects: The government may support financing of PPP arrangements through various measures including the issuance of letters of credit and credit or risk guarantees.[321]

The Public-Private Partnerships (PPP) Directorate

It acts as the technical arm of the PPP Committee with the overall mandate of facilitating the implementation of the PPP programmes and projects in Kenya.

[318] Section 3 (a), The Public-Private Partnerships Act, No. 14 of 2021.
[319] Section 4 (1), ibid.
[320] Section 2 (definition of a PPP), ibid.
[321] Section 28, ibid.

County Governments Act
Permits country governments to enter PPP arrangements with private actors in compliance with the PPP legal regime.[322]

The Kenya Health Public Private Collaboration Strategy, 2020
The strategy seeks to promote and embed private sector participation in health service delivery through PPP arrangements. It lists the available financing options for PPPs including both direct (and indirect government financing such as waivers of fees, levies and taxes, subsidies and equity investments.[323]

Tanzania

Public Private Partnership Policy 2009
The aims to create an enabling environment for promotion and facilitation of PPPs including in socio-economic sectors such as health and education. One of the policy objectives is to promote PPPs in regions which are geographically and economically disadvantaged in Tanzania.

Public Private Partnership (PPP) Act (as Amended in 2023) and Public Private Partnership Regulations 2020
The Act permits government bodies and local government authorities to contract with private entities to offer public services, including health and education.[324] The law enjoins the State to create a favourable policy environment for PPPs to facilitate PPPs.[325]

Risk allocation: The Act requires private parties to assume the risks (financial, technical and operational) in the PPP arrangement.[326]

[322] Section 6, County Governments Act.
[323] The Kenya Health Public Private Collaboration Strategy, 2020 at p. 23-25.
[324] Sections 3 and 4 (5) (e) & (f), Public–Private Partnership (PPP) Act.
[325] Section 8 (e), ibid.
[326] Sections 3 (definition of a PPP) and 11 (4) (b), ibid.

Financing: This law permits the government to support PPP projects through direct funding (fiscal commitments or contingent liabilities) as well as tax incentives.[327] The Act also creates a PPP Facilitation Fund through which viable projects may be funded.[328]

Public Private Partnerships Centre
The Centre is tasked with the promotion and coordination of public-private partnership projects in the productive and social sectors such including education and health.[329] It also coordinates the PPP Facilitation Fund.

Rwanda

Law N°14/2016 of 02/05/2016 Governing Public Private Partnerships
The Act lists potential sectors under which PPP projects can be developed including education and health.[330]

Public Private Partnership Guidelines
The Guidelines support the delivery of public infrastructure and services through PPPs in Rwanda. The Guidelines outline the procedures and requirements for the implementation of PPP projects.

Risk allocation: the contracting authority determines if the risks identified are to be retained, transferred to the private actor or divided between the government and the private actor.[331]

[327] Section 7B (4) of the Act defines public funding as "government financial support that constitutes fiscal commitment or contingent liabilities in relation to a PPP project." See also, Section 10B (3), ibid and Section 12 of the PPPs (Amendment) Act.
[328] Section 10B (2), ibid and Regulation 30 (7) of the PPP Regulations.
[329] Section 4 (4) & (5) (e) & (f) of the Public Private Partnership Act Cap 103.
[330] Article 5 (3), Law N°14/2016 of 02/05/2016 Governing Public Private Partnerships.
[331] Public Private Partnership Guidelines at p. 30.

Financing: The government may support projects through financial contributions and guarantees.[332]

PPP Steering Committee
The Steering Committee is responsible for approval and oversight of PPP projects.[333]

Rwanda Development Board
The Board is tasked with leading negotiations for PPP arrangements and advising the government on PPPs. It also serves as the Secretariat of the PPP Steering Committee and supports the approving and overseeing PPP projects.

While supporters of PPPs raise benefits such as efficiency, effectiveness and value for money as justification for the use of the model, evidence of PPPs in health and education in the region has demonstrated otherwise.[335] All four countries permit the governments to make financial contributions to PPP projects and offer a myriad of policy incentives such as waivers of fees, tax incentives, guarantees and subsidies. The domestic laws on PPPs of three of the study countries (Kenya, Uganda and Tanzania) indicate that the risks of PPPs are to be borne primarily by the private sector.

However, there is evidence to contrary showing that these governments are taking on far more financial risks than the private sector. The (in)famous Lubowa international hospital project in Uganda is a key example. It was promoted as a high end specialized facility targeting Ugandans who seek healthcare abroad.[336]

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[332] Ibid, p. 32-33 and p. 36.
[333] Articles 6-9, Law N°14/2016 of 02/05/2016 Governing Public Private Partnerships.
[334] Article 10, Law N°14/2016 of 02/05/2016 Governing Public Private Partnerships.
[335] See Amanda Stucke, "Public-Private Partnerships for Emerging Market Health" (2019) International Finance Corporation (IFIC).
See also, The Economic and Social Rights Centre – Hakijamii and the Center for Human Rights and Global Justice, "Wrong prescription: The impact of privatizing healthcare in Kenya" (2021) at p. 21.
[336] ISER, "A false promise: The Lubowa international specialized public private partnership (PPP) hospital will not deliver universal health in Uganda" (2023).

In 2019, the Ugandan government announced that it borrowed **$379.71 million** (UGX 1.3 trillion) for this project, beyond the stated project cost of approximately **$250 million** in addition to granting tax exemptions to the investor.337 For context, this loan was more than half of the health sector budget for FY2019/20.[338] The project has been marred with numerous scandals,[339] claims of incompetence on the part of the private investor[340] and alleged irregularities such as debt contracting without prior approval of Parliament.[341]

PPP arrangements typically have high financial implications for States. The above Ugandan example demonstrates that PPP projects are potentially more expensive than direct public investment in public services.[342] In addition, the contingent liabilities associated with such PPP projects are often not disclosed to the public nor calculated in the government's overall debt burden.[343] As of 2023, according to the World Bank Debt Reporting data, only Rwanda reports specific information on its fiscal risk exposure from PPP projects under its contingent liabilities indicating project values.[344]

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337 Ibid. See also, Tim Jones, "Fears raised about cost of PPP hospital in Uganda" (2019) Debt Justice available at https://debtjustice.org.uk/blog/fears-raised-about-cost-of-ppp-hospital-in-uganda (accessed on March 31, 2024).

338 The health sector budget for FY2019/20 was UGX 2,278 billion. See, UNICEF, "The National Budget Framework FY2019/20" (2019) Budget brief No. 2019/3.

339 Misairi Thembo Kahungu, "Overspending on the Lubowa Specialized Hospital project comes back to haunt Parliament" (2024), Parliament Watch available at https://parliamentwatch.ug/news-amp-updates/overspending-on-the-lubowa-specialised-hospital-project-comes-back-to-haunt-parliament/ (accessed on March 31, 2024).
See also, Josselin Canevet, "Lubowa Hospital: A case study in corruption risk – and how open contracting could have helped" (2019) Transparency International available at https://ti-health.org/content/lubowa-hospital-news-uganda-open-contracting/ (accessed on March 31, 2024).

340 Ibid.

341 This is subject to ongoing litigation in Ugandan Courts. See ISER v the Attorney General, Constitutional Petition No. 7/2019.

342 Daniela Gabor, supra.

343 Ibid.

344 World Bank, "Debt Reporting Heat Map" (2024) available at https://www.worldbank.org/en/topic/debt/brief/debt-transparency-report/2023 (accessed on March 30, 2024).
See also, Rwanda Fiscal Risk Statement FY 2023/24 at p. 19-21. While Kenya reports on its guarantees by beneficiary, it does not provide specific information on PPPs in its reporting of contingent liabilities. Tanzania reports on its contingent liabilities by type without specific information. Uganda has not updated its reporting on its contingent liabilities in recent years.

The high financial cost associated with PPPs could potentially result in high charges for the services offered, exacerbating inequality in access to services. Research conducted on implementation of some PPP projects in the delivery of public services in the region has found that they are not an effective means of reaching the poorest households and vulnerable groups.[345] Under legal and policy framework on PPPs in the region (Box 3 above), there is no requirement for private investors to take into account human rights considerations in implementation of PPP projects in public service delivery.

International financial institutions such as the World Bank have widely promoted public private partnership (PPP) arrangements in the study countries amidst reducing concessional financing and development aid for social services. A recent World Bank study proposed that the Tanzania considers investment in low cost private secondary schools through a PPP arrangement as a solution to the "over-stretched public education system."[346] It is important to note that a similar Ugandan experience with PPPs for secondary education, with the backing of the World Bank, was unsuccessful and eventually phased out in 2018.[347] Some of the grounds cited for this decision included lack of accountability and low access for the poorest thus the need to channel the funds towards investment in public school infrastructure instead.[348]

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[345] ISER, "Failing to reach the poorest? Assessment of the World Bank Funded Uganda Reproductive Health Voucher Project" (2020).
See also, Crystal Simeoni and Wangari Kinoti, "Medical equipment leasing in Kenya: Neocolonial global finance and misplaced health priorities" in Development Alternatives with Women for a New Era (DAWN), "PPPs & Women's Human Rights: Feminist analysis from the Global South" (2021) DAWN Informs.

[346] Shwetlena Sabarwal, et al, "Low-Cost Private Schools in Tanzania: A Descriptive Analysis" (2020) World Bank Policy Research Working Paper No. 9360.

[347] For more on the human rights concerns with respect to PPPs in universal secondary education in Uganda, see Initiative for Social and Economic Rights (ISER), 'Threat of Opportunity: Public Private Partnership in Education in Uganda,' (2016).
See also, World Bank, "Uganda Secondary Education Expansion Project: Project Information Document" (2018) at p. 18.

[348] World Bank, ibid.
See also, O'Donoghue et al, "A review of Uganda's Universal Secondary Education Public Private Partnership programme," (2018) Education Partnerships Group.
See also, Ahimbisibwe P, "Govt to stop funding to 800 private USE schools, Daily Monitor," Wednesday, January 17, 2018 — updated on January 13, 2021 at https://www.monitor.co.ug/uganda/news/national/govt-to-stop-funding-to-800-private-use-schools-1736078 (accessed on December 14, 2023).

Aspect 4: Private debt as an effect of commercialization of public services

Recent financial surveys in the region have revealed that people are increasingly borrowing to meet the education and health care related expenses (Box 4). This can be attributed to multiple factors including increased vulnerability, especially in the aftermath of the COVID-19 pandemic, high charges for public services provided by private actors and low government investment in public services.[349]

30%

In 2021, UNESCO reported that 30% or more of households in Uganda and Kenya are borrowing to meet the school fees and requirements for their children's education.

Box 4

Trends of increased borrowing to meet health and education expenditure

Kenya

Education ranks highly among the main life priorities of adults in Kenya – 35.5% in 2019 and 30.2% in 2021.[350] In 2021, during the COVID-19 pandemic, vulnerability increased among Kenyans with 54.2% reporting having to forego health care while 54.3% of children were sent home for failing to pay fees.[351]

[349] UNESCO (2021), Global Education Monitoring Report 2021/2: Non-state actors in education: Who chooses? Who loses? Paris, UNESCO.
[350] Central Bank of Kenya et al, "2021 FinAccess Household Survey" (2021) at p. 56.
[351] Ibid. at p.64.

Kenya

Education as priorities of adults in Kenya

35.5% in 2019

30.2% in 2021

Education **54.2%**

Health **54.3%**

According to a customer survey conducted by Tala Money, a digital financial lender operating in Kenya, education (27%) and health expenses (15%) are among the reasons why customers borrow.[352]

Education **27%**

Health **15%**

Rwanda

The 2023 Rwanda Labour Force Survey Annual Report indicates that the median monthly salary from paid employment is RWF 26,000 while the average salary is RWF 68,481.[353] Data from a 2020 financial survey indicates that school fees (16%) and medical expenses (4%) featured among the reasons for borrowing among Rwandan adults.[354]

median monthly salary from paid employment **RWF 26,000** while the average salary is **RWF 68,481**

[352] Tala Money March Report (2023) available at https://tala.co.ke/wp-content/uploads/sites/2/2023/03/Tala-MoneyMarch-Report-2023.pdf (accessed on March 31, 2024).
[353] Rwanda Labour Force Survey Annual Report 2023 at p.v.
[354] Access to Finance Rwanda, "FinScope, Rwanda: Consumer Survey Report 2020" at p. 51. https://www.statistics.gov.rw/publication/finscope-rwanda-2020

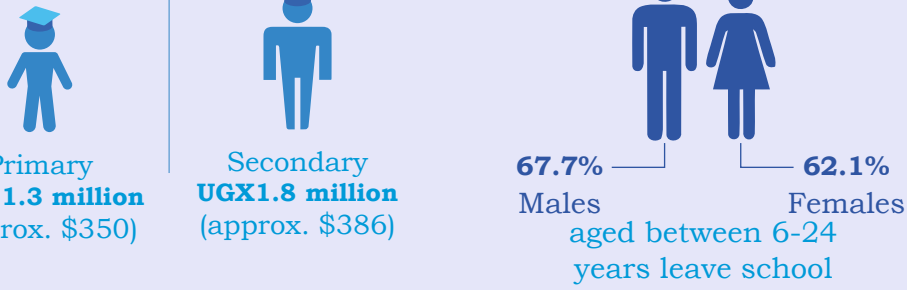
Rwanda

School fees
16%

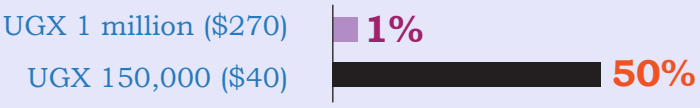
Medical expenses
4%

Uganda

According to the Uganda National Household Survey (UNHS) 2019/20, households in Kampala spend an average of UGX 1.3 million (approx. $350) and UGX 1.8 million (approx. $386) on primary and secondary education respectively.[355] Lack of funding and the high cost of education rank highly among the reasons why males (67.7%) and females (62.1%) aged between 6-24 years leave school.[356]



The Central Bank estimates that 50% of working Ugandans earn less that UGX 150,000 (approx. $40) and only 1% earn above UGX 1 million (approx. $270).[357]

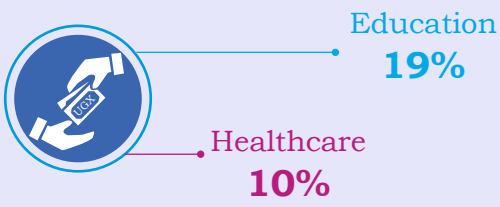


[355] Uganda National Household Survey at p. 24-26 available at https://www.ubos.org/wp-content/uploads/publications/09_2021Uganda-National-Survey-Report-2019-2020.pdf (accessed on March 31, 2024).

[356] Ibid. at p. 29.

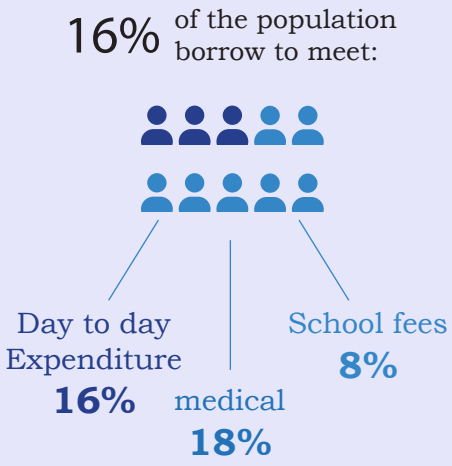
[357] Bank of Uganda, "Financial Capability Survey 2020" at p. 12 available at https://www.ktaadvocates.com/wp-content/uploads/2023/12/Financial-Capability-Survey-2020-Report.pdf ((accessed on March 31, 2024).

The UNHS cites education (19%) and healthcare expenses (10%) among the reasons why Ugandan adults borrow.[358]



Tanzania

According to a 2023 financial survey, 16% of the population (3 in 10 people) borrows to meet their day to day expenditure.[359] Specifically, it was noted that medical expenses (18%) and school fees (8%) were among the reasons why adults borrowed in the past year.[360] Medical expenses also featured as one of the large shocks which impacted earnings of the adults (23%).[361]



Data on digital lending in Kenya and Tanzania shows that digital credit is increasingly being used for meeting health and education related expenses.[362] While its celebrated as a milestone for financial inclusion, there are human rights concerns associated with digital lending. Specifically, it has been reported that

[358] Uganda National Household Survey, supra at p. 236.
[359] Tanzania Ministry of Finance et al, "FinScope Tanzania 2023" at ap. 36.
[360] Ibid. at p. 63.
[361] Ibid at p.65.
[362] Kenya Financial Sector Deepening (FSD), "Digital Credit Audit Report: Evaluating the conduct and practice of digital lending in Kenya" (2019) at p.23.
Juan Carlos Izaguirre et al, "Its time to slow digital credit's growth in East Africa" (2018) CGAP available at https://www.cgap.org/blog/its-time-to-slow-digital-credits-growth-in-east-africa (accessed on March 31, 2024).

lenders employ predatory practices in violation of borrowers' rights to privacy.[363] While some countries such as Kenya and Uganda have adopted regulations in light of complaints raised,[364] this is an area for further research in the context of commercialization of public services.

[363] Centre for Intellectual Property and Information Technology Law (CIPIT), "Privacy and data protection practices of digital lending apps in Kenya" (2021) Journal of Intellectual Property and information Technology Law, Volume 1, Issue 1.

[364] See Central Bank of Kenya (Digital Credit Providers) Regulations, 2022 and Uganda Digital Lending Guidelines for Tier Four Microfinance Institutions and Moneylenders, 2024.

7

Conclusion and Recommendations

7. Conclusion and Recommendations

Profit oriented delivery and financing of public services by private actors is negatively affecting availability and access to quality health and education services in the East African region. The government's key role as provider and regulator of service delivery is increasingly shrinking to an inferior one of a facilitator and enabler of private actors. A general reading of the current legal and policy framework governing health and education services in the region reveals a stronger bias for creating a favourable environment for private actors than strong regulation to ensure protection from human rights violations. From a human rights perspective, commercialization is a threat to the fundamental principles of equality and non-discrimination, accountability and participation in the context of education and service delivery.

The study makes the following recommendations:

01 States should take the lead in the provision of public services and private education should not replace public education as it is likely to exacerbate the existing inequalities in access to education, especially for children from poor or low-income backgrounds.

02 States should strengthen government delivery of health and education services through an increase public funding, at government and county or local government level. The regulation of private health providers is not sufficient in itself. It needs to be backed by sufficient public funding of the health system to ensure that the poor and vulnerable are not excluded from accessing health services.

03 States should take necessary measures to improve access to and the quality of primary education for all without hidden costs. This includes regulating school fees and health care charges in both public and private schools and health facilities.

04 With respect to low cost schools, it is crucial to note that an increase in the number of schools available is not a milestone in itself if the human right to education is not being realized. Where private actors are permitted to operate schools, States should ensure that they meet the minimum standards and are routinely monitored and inspected.

05 States should ensure that private actors have a public function ethos in their service delivery and respect human rights. This can be achieved through adoption of policies and laws which emphasize the public nature of these services and the need to adopt a human-rights based approach to service delivery.

06 States should strengthen the regulation of private actors in health and education. Particularly, there is need to adopt monitoring and evaluation frameworks to assess the performance of private health and education service providers.

07 States should adopt a human rights approach to contracting and implementing PPPs. This will entail conducting a cost-benefit analysis of funding private investments over public investment in health and education sectors. They should put in place substantive, procedural and operational requirements with respect to service delivery by private actors in health including under PPP arrangements. It should be a requirement for the State and private investors to take into account human rights considerations in the structure and implementation of PPP projects in the health and education sectors.

8

Annexes

8. Annexes

Annex 1: Court Decisions from the East African region related to commercialization of health and education services

Health	
Regulation of charges or levies by private health facilities	***Moses Mulumba & Ors v AG & Ors (Uganda).***[365] The parties agreed on the need for the State to regulate medical bills for the COVID19 treatment by setting "reasonable fees". However, this term is rather generic, broad and subject to varying interpretation by regulators, private health facilities and their clients. ***Health Equity and Policy Initiative v Hon Jane Ruth Acheng Ocero, Minister of Health and Anor (Uganda).***[366] The court took a stronger stance on this issue, ordering the ministry of health to adopt legislation regulating and standardizing rates and charges levied by private health facilities. It stated: …in failing to make the necessary laws to regulate private medical facilities in as far as medical levies, charges and other related matters are concerned, the Respondents (the Ministry of Health) are complicit in the violation of the right of health of patients in Uganda. This trend of violation is more likely to continue unless the Respondents take corrective measures to avert the threatened future violation.

[365] Moses Mulumba & Ors v AG & Ors, High Court Miscellaneous Application No. 489 of 2021.
[366] High Court Miscellaneous Cause No. 210 of 2018 (2024).

Detention of patients in health facilities for failure to pay medical bills	***Center for Health, Human Rights, and Development (CEHURD) and Ors v Jaro Hospital Limited & Anor (Uganda).*** Having weighed the arguments on both sides, the court held that detention of patients a violation of the right to liberty and hospitals should utilize other means to recover their costs. ***Millicent Awuor Omuya & and Margaret Anyoso Oliele v. The Attorney General & 4 Others (Kenya)***[367] the petitioners were detained in the hospital for failure to pay hospital bills after giving birth. The court observed that Article 43 of the Constitution entitles everyone to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 27 contains non-discrimination provisions, which decree that neither the state nor any person shall discriminate against any person either directly or indirectly on any ground. Specifically, on the right to health, the Court observed that the right to health and the right to dignity are inextricably related. In providing health care of acceptable quality, healthcare institutions must respect the dignity of their patients. The aspect of accessibility which requires non-discriminatory access to health facilities, goods and services, especially [for] the most vulnerable or marginalized sections of the population was emphasized. Additionally, it was averred that accessibility also requires that

[367] [2015] Petition No. 562 of 2012.

health services be available and free from discrimination; they must be physically and economically accessible, and they must be affordable.[368]

The court further held that the petitioners were discriminated against because of their economic status. They were denied access to healthcare facilities due to their inability to pay. When they were, very grudgingly, given treatment, they were detained due to their inability to pay, and while at the hospital, they were denied basic provisions such as beds, and bedding, and the food they were given was insufficient. It held "we have not, as a society, clearly internalized the fact that denial or neglect to provide interventions that only women need is a form of discrimination against women. As such, the lack of state provision or facilitation of access to affordable maternal health care, including delivery and post-natal care, is a facet of discrimination against women."

Emmah Muthoni Njeri v Nairobi Women's Hospital (Kenya).[369] The respondent unlawfully detained petitioner for six months for failure to meet her medical expenses. The court found that the unlawful detention of the Petitioner for failure to pay the hospital charges violated her dignity, right to freedom and security of the person, and right to freedom of movement. That the respondent should have used other lawful mean to recover the money and not detention.

[368] The court quoted Article 12(2) (d) of the CESCR and paragraph 17 of General Comment No. 14 on the right to health.
[369] [2021] eKLR.

	Gideon Kilundo & Daniel Kilundo Mwenga v Nairobi Women's Hospital (Kenya).[370] The petitioner was detained for failing to clear medical bills after receiving treatment. The court held that: "while it is true that the relationship between the petitioners and the respondent was a contractual one for which the respondent should pursue other lawful means of recovering the debt other than detaining their former patient, this court is of the view that it does not augur well for the dispensation of justice for persons to walk into private hospitals for treatment and expect to walk out without paying a single cent under the guise of the constitutional protection of liberty and freedom of movement."
Regulation of private actors in heath – meeting minimum standards	***Host & Ane Dispensary Associates Company Limited Vs Kinondoni Municipal Council (Tanzania).***[371] The plaintiff sued the defendant for closing its clinic and dispensary for among others not complying with the established standards contained in the Private Hospitals (Standard Guidelines Health Facilities) Regulations, G.N. No. 233 of 1997 Additionally, the dispensary and clinic's license had expired that justified the closure by the defendant. The plaintiff sought a declaration that the closure of the plaintiff's business by the defendant was unlawful and was done without proper authorization. The court found that the defendant exercised its duty of closing the Authority and could not be held liable.

[370] [2018] eKLR.
[371] Civil Case No. 150 of 2015.

Education	
Financing of PPPs and their supervision, regulation and monitoring.	***Initiative for Social Economic Rights v Attorney General (Uganda).***[372] The applicant challenged the discrepancy in government financing for secondary education in public, government aided schools that were receiving more funding compared to PPP schools resulting in poor quality education in PPP schools. The government denied responsibility for the poor quality education and argued that in PPP schools were self-regulatory. The court held that under domestic and international human rights law, the Government has obligations to monitor, regulate, ensure private schools including PPPs comply with the regulations. It directed the Government to take its lead position in regulating private involvement in education to ensure adherence to minimum standards and enforcement of sanctions to defaulters.
Regulation of private actors in education	***Bridge International Academies (K) Ltd v Attorney General (Uganda).***[373] The applicant opened and operated over 60 academies without a license from the Ministry of Education and Sports (Regulator) and without complying with minimum education standards. The court established that Private schools cannot operate in contravention of the law, including laws setting out minimum educational standards.

[372] Civil Suite No. 353 of 2016 (Judgement 17 July 2019)
[373] (Miscellaneous) Application No. 2511 of 2016) [2017] UGCOMMC 17 (17 January 2017)

	Further, the regulator mandated to promote quality control of education and training can exercise the power to close institutions that do not comply with the set minimum standards and the law.
Regulation of school fees	***Michael Aboneka & Ors v Attorney General (Uganda).***[374] The applicants sought prerogative orders of mandamus to compel the Minister in charge of education to immediately perform the statutory duties under sections 3 and 57 of the Education Act and issue statutory instruments to regulate schools. The court dismissed the application on a procedural technicality that the applicants did not first write to the Minister demanding her to fulfil her obligations. However, it established that the minister has the duty to regulate school fees in all schools including the private ones although the law does not prescribe the timeframe with which the Minister has to issue the regulations.
Regulation of private actors	***Republic v The County Education Board & Ors (Kenya).***[375] Bridge International Academies challenged the decision of the County Education Board to close its schools before their registration. The court held that the basis upon which Bridge International Academies was challenging the closure of its schools was aimed at conflating the role of the Council in the processing of an application for the registration of school and the inspection of an already established school. These two roles are distinct.

[374] Misc Cause No. 15 of 2022
[375] Judicial Review No. 3 of 2016.

	On one hand, the council's role is to establish whether a proposal meets the standards for registration and on the other hand, to ensure that the school which is already registered continues meeting the standards. Where an application for registration is rejected, the school is shut down. The Court further held that the county board acted legally to decline the registration of the school for not meeting the standards and consequently closing the schools.
Public accountability for public services provided by private actors	***Bridge International Academies Ltd v Kenya National Union of Teachers & Anor (Kenya).***[376] was an application for injunctive reliefs against the respondents for commenting on the operations of Bridge International Academies to wit operating without a license, employing unqualified teaching staff was injuring its reputation and thus defamatory. In dismissing the application, the court held; "…the centrality of the role of the respondent in basic education in the life and affairs of the nation cannot be understated. As such there can be no doubt that matters of education in this country are matters great public concern. Not only does the constitution guarantee every child the right to basic education, it is also a fact that education is of such importance that the public are often engaged in questioning the happenings in public and private education issues at all times."

[376] HCCS No. 59 of 2017

Annex 2: External debt repayments (principal and interest) over the past decade ($ millions)

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
UG	66.2	79.2	95.5	86.1	101.2	177.4	321.7	280.8	319.8	618.2	691.7
KY	475,6	451.1	1,230.2	679.9	771	1174	2,311.9	3,980.7	2,460.4	2,081.4	2,960.8
TZ	88.9	213.2	192.8	345.7	617.4	702.2	920.3	1,138.9	1,199.3	1,539.2	1,545.1
RWA	20.6	37.3	52.9	56.6	64.8	73.4	80.3	87.2	113.3	461.3	166.2

Source: World Bank International Debt Statistics

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